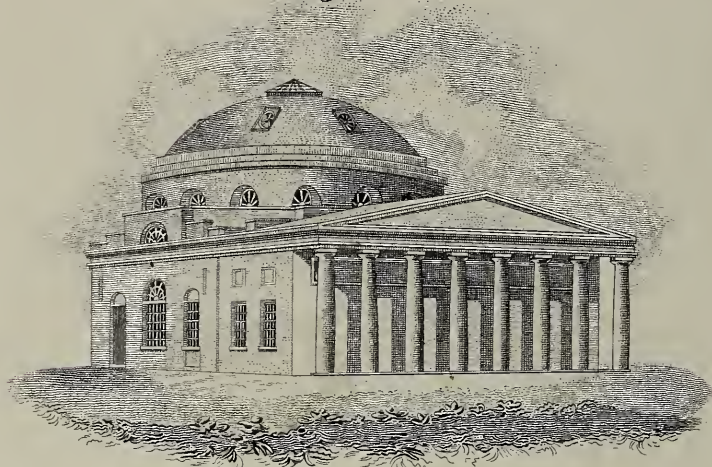




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# The 110 STATE MEDICAL JOURNAL

JANUARY, 1945

Vol. 41

Number 1

FEB 12



Regulations of Veterans Administration  
on the Care of Disabled Servicemen  
by Civilian Physicians and Hospitals

*Pages 51-53 This Issue*



# The Ohio State Medical Journal

Vol. 41

January, 1945

No. 1

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, \$3.00 per year to non-members; Single Copy, 30 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to standards and regulations established by the American Medical Association.

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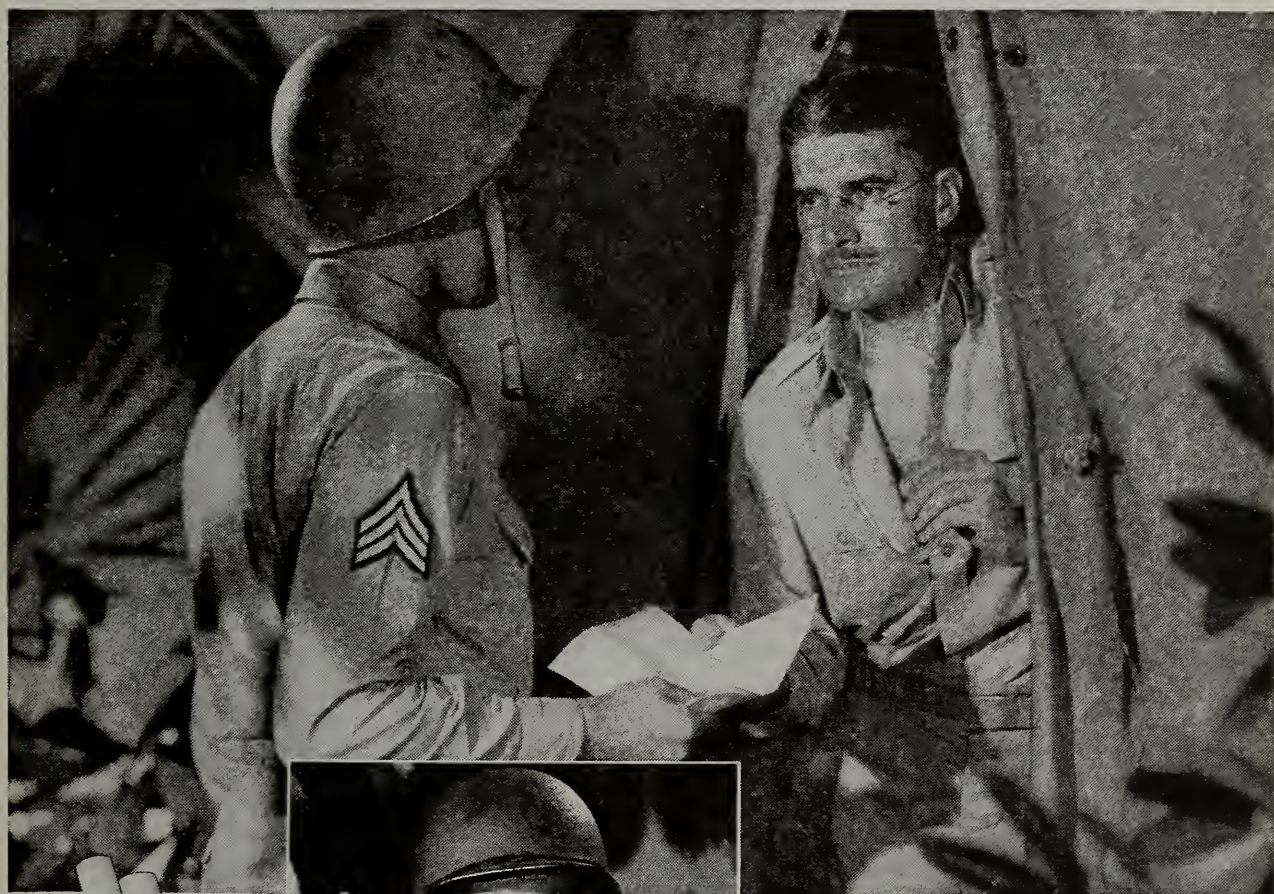
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# CAMELS

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(Continued from page 8)

handbooks. This by the leaders at University of Iowa. While it emphasizes the X-rays, it is nevertheless an excellent review of urology. It belongs therefore to internists, radiographers, and surgeons alike.

**Operations of General Surgery**, by Thomas G. Orr, M.D., with 1596 step-by-step illustrations and 570 figures, (\$10.00. *W. B. Saunders Co., Philadelphia*) attempts to provide for all the usual and special operations which a general surgeon is called upon to make realizing that the general surgeon must be able to do the usual operations in all the special fields, if he is to be a general surgeon. A valuable book, beautifully executed.

**Joseph Lister, Father of Modern Surgery**, by Rhoda Truax, (\$3.50. *The Bobbs-Merrill Co., Indianapolis*) tells the dramatic story of this man who drove infections from the operating room by his discovery of the practical application of antiseptics.

**Normal Lives for the Disabled**, by Edna Yost in collaboration with Dr. Lillian M. Gilbreth, (\$2.50. *The Macmillan Co., New York City*) is dedicated to the thesis that self-respect and happiness can be obtained by handicapped men and women. The book discusses the problem of making up your mind to work, the business of getting ready to work, the problems when on the job and a discussion of the future. We consider this an important and very much needed book. It offers a comprehensive picture of the magnitude of the problem and of what has been and is now being done to help wounded men and women rehabilitate themselves. To read it should encourage them and it should also encourage all who have to deal with handicapped people, as it gives concrete examples of success, psychological and spiritual approach to the problems of the handicapped, both from their point of view and from the point of view of those who come in contact with them.

**Nurse Please!**, pictured by Jean McConnell (\$1.00. *J. B. Lippincott Co., Philadelphia, London, Montreal*) is a series of clever drawings emphasizing some of the funny situations encountered by girls in training and, therefore, makes a nice little gift.

**A Textbook of Pathology**, by Robert A. Moore, M.D., (\$10.00. *W. B. Saunders Co., Philadelphia*) presents the subject in a logical arrangement. The approach by disturbances of metabolism rather than by the anatomic degeneration is a departure and, we believe, a good one. It is a pleasure to this reviewer to read this summary of the vast knowledge of the author, which began in the same old laboratory in which we began the study of disease. The book is highly recommended.

**The Daily Log for Physicians** (*Colwell Publishing Co., Champaign, Ill.*), presents again the sound and simple method of keeping accounts. In these days of continually increasing governmental snooping such a system becomes invaluable. In this one Doctor Colwell has stood the test of time.

**Essentials of Pharmacology and Materia Medica for Nurses**, by Albert J. Gilbert, M.D., and Selma Moody, R.N., (\$2.50. 2nd Ed. *C. V. Mosby Co., St. Louis*) brings up to date this practical little volume for nurses. The senior author is one of us, being instructor in pharmacology in the Aultman School of Nursing in Canton, Ohio.

**Heart Disease. An Elementary Reference for Physicians**, by Robert S. Berghoff, M.D., (*Circular No. 176, Illinois State Dept. of Health*) is a brief elementary work on heart disease presented as an extension of the services rendered by the Postgraduate Committee of the Illinois State Medical Society to the profession of the state and is an attempt to "refresh" the doctor remaining behind in civilian practice. It is an excellent little manual.

**Endocrinology. A Brief Review for Physicians**, by James H. Hutton, M.D., (*Circular No. 117, Illinois State Dept. of Health*) is one of the same series of the previous volume and condenses into 169 small pages of bold readable type the practical facts in this important field that has an all too voluminous literature.

**The Psychiatry of Robert Burton**, by Bergen Evans in consultation with George J. Mohr, M.D. (\$2.00. *Columbia University Press, Morningside Heights, N. Y.*) Sir William Osler called "The Anatomy of Melancholy" "the greatest medical treatise ever written by a layman". A psychiatrist and a professor of English here offer a fresh evaluation of Robert Burton's book showing how close he came to modern psychological insight into mental and emotional disorders. It is the first full length presentation of Burton's psychiatric theories in the light of modern psychological knowledge. Intelligent laymen, as well as students of English literature and psychiatry, will find this book stimulating and valuable.

**Special Delivery; The Expectant Mother's Handbook**, by B. D. Rosenberg, M. D. (\$2.00. *Ziff-Davis Publishing Co., Chicago*) is a cleverly written and illustrated handbook for the expectant mother. It goes very heavily into the anatomy and this probably is the expectant mother's major curiosity.

**A Study of Endometriosis**, by James R. Goodall, M.D., (\$5.50. *J. B. Lippincott Co., Philadelphia*) is a volume intended to present the whole subject. This means that every student of the diseases of the uterus, tubes, and ovaries must have this volume.

# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

January, 1945

No. 1

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## Factors Which Influence Success in the Administration Of An Anaesthetic

N. A. GILLESPIE, D.M.

IT is necessary, before we discuss the factors which produce that desirable result, to define our concept of a successful administration of anaesthesia. Three persons are concerned: The patient, the surgeon, and the anaesthetist; and the respective desires of the first two have been summed up wittily as well as accurately by Helen Lukis<sup>1</sup>:

"The average patient desires five things only: that the anaesthetic shall be: (1) one hundred per cent safe; (2) pleasing to take; (3) quick in action; (4) have no unpleasant after-effects; (5) keep him unconscious until all post-operative pain and discomfort are over. Some, of course, would prefer that the amnesia began the moment the surgeon said 'you need an operation' and lasted until they left the hospital.

"The surgeon's ideal anaesthetic is also, of course, 100 per cent safe. It must allow him complete and uncrowded access to whatever part of the body he is interested in at the moment. Haemorrhage must be sufficiently checked to prevent any tendency to oozing, but not so reduced that essential points escape notice. Muscular relaxation must be complete. The respiratory movements should be as small as possible without disturbing his peace of mind as to whether the patient is breathing or not, and post-anaesthetic symptoms should be few or absent."

To the anaesthetist a successful administration is one in which the patient's and surgeon's desires have been simultaneously satisfied with agents and methods which have provided smooth

### *The Author*

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induction, tranquil maintenance, ideal conditions for operation, and a convalescence free of complications. Any given administration, then, can not be truly described as successful until the patient leaves the hospital. We must not rest content with a less exacting standard of "success" than this. If we develop a tolerance towards indifferent workmanship our standards gradually degenerate until that which last week was regarded as a bad administration is not so bad today, and will come to be regarded as quite satisfactory a few weeks hence. Nor shall we reach the highest competence unless we study to do our work "suaviter in modo" as well as "fortiter in re"; and ever strive to make each administration artistically perfect as well as scientifically sound. Perfection itself must be our ideal.

### FACTORS OF SUCCESS

The factors which influence such a success may be grouped under two main heads: the personal ones and the technical ones. Of the personal

<sup>1</sup>Presented at the Annual Meeting of Ohio Society of Anesthetists, held in conjunction with the Ninety-Eighth Annual Meeting, Ohio State Medical Association, Columbus, May 3, 1944.



factors the first is the relation existing between anaesthetist and patient.

A wise and skilful anaesthetist once remarked:<sup>2</sup> "Just as some great leaders have made timid men follow and perform valiant deeds, so most experienced anaesthetists can handle timid patients and make them rise to the occasion. Personality is non-toxic and does not throw any strain on the heart, liver or kidneys; nor does it depress respiration."

It is customary nowadays for the anaesthetist to visit patients before operation in order to evaluate their physical condition and place it on record. In private practice, if some medical man has not already performed a general examination of the patient, this duty devolves upon the anaesthetist. In a hospital, however, residents or interns usually record the pertinent facts.

The wise anaesthetist, even though he may copy the facts established by someone else, will not neglect the opportunity to make himself acquainted with the patient. For if he can, in the course of a brief interview, inspire in the patient a sentiment of confidence in him as an honest and sympathetic person, he will have laid the foundation of a tranquil induction more surely and more safely than can be done with depressant drugs.

The modern fashion of excessive enthusiasm for the "scientific" aspect of medicine has, alas, resulted in a relative neglect of its artistic moiety. The general practitioner sins less in this respect than the consultant, who, if he knows more about a patient scientifically, usually knows much less about him personally. The function of a medical man is the treatment of a patient, and a patient is a human being who unfortunately suffers from a disease. He is not an interesting pathological condition to which a human being is inconveniently attached.

In the course of a short visit, then, we should try to make friends with the patient. We should listen with interest to any details he cares to recount of previous experiences of anaesthesia—and weigh them for what they are worth!—and we should enquire as to any particular likes or dislikes that he may care to express. We should dispel the "terror of the unknown" by explaining to him what will be done for him and what he may expect.

Usually during such a conversation, with a previous knowledge of the operation and the condition of the patient, the anaesthetist will be mentally forming his "plan of action". This will depend in part upon the patient's physical condition, partly on the nature of the operation, and to some extent on the "hunch" as to the idiosyncrasies of that particular patient which the anaesthetist develops in the course of this interview. In a recent article<sup>3</sup> I said, of this "hunch":

"Patients are of certain types which can be

recognized at sight after some experience. The large and "tough" men who will probably fight on induction; those with short, wide necks who are wont to develop respiratory obstruction; those who are red-headed, liable to sudden accidents of circulation or respiration, and showing cyanosis easily; the anaemic who can die of hypoxia when of a vaguely slate-grey color; the terrified and tense who are prone to sudden circulatory collapse and who require full saturation to obtain relaxation; and the desperately ill in whom a ludicrously small amount of the agent will produce deep anaesthesia".

The nostrils and teeth should always be examined. The shape of the former is of importance in the event of nasal intubation, and the state of the latter should be known no matter what form of anaesthesia is contemplated. Loose and fragile crowns and bridgework should be carefully noted. If incisor teeth are very loose and pyorrhoeic it is often wise to discuss them with the patient. As a rule he will volunteer the statement that his dentist has advised their extraction, and he will agree readily enough with one's suggestion that, should they be in danger of being displaced and aspirated into the trachea, one may remove them.

By the time the interview has been proceeding for five minutes the anaesthetist should have reached a decision as to how he intends to produce anaesthesia, and be in a position to explain this to the patient. As a rule patients are content to leave the choice of agent and method to the anaesthetist. Sometimes they ask that ether shall not be used in their case. If so, the request is usually prompted by bitter recollection of an unsavory previous experience of inept induction with this agent. I am rarely prepared to promise beforehand that I will not use it, but always state that it will not be used until they are unconscious. Often they never realize that they have had it. It is most important to be strictly truthful, and to promise no more than one is sure of being able to perform.

#### A PROFESSIONAL SERVICE

An excuse which is sometimes offered for regarding the professional services rendered by anaesthetists, radiologists, and pathologists as purely technical is that no personal contact exists between consultant and patient. Where this is true it is most unfortunate, for the absence of personal relation has often been used by hospitals as an excuse for putting salaried technicians in charge and collecting private fees from the patient. To a patient it naturally seems absurd to pay a private fee to a person of whose existence he is scarcely aware; and it is the anaesthetist's duty to make him understand that an anaesthetic administration is an important part of his treatment.

The second of the personal factors is the re-



lation which exists between anaesthetist and surgeon. I do not propose to dwell on this at length, for I have made several recent pleas in print<sup>4,5</sup> for closer understanding and co-operation between these two. The best results are only obtained when there is complete mutual confidence, and this can only come from an experience of each other. It follows that time is necessary for each such pair to learn to know each other; for no reputation, however distinguished, can create the confidence which is based on personal experience.

If we are to win a surgeon's respect, however, we must give proof of surgical common-sense as well as of medical learning. We must cultivate a reasonable sense of proportion with which to equate surgical urgency and medical expediency. In doing so we must always remember that whereas we may be entitled to the opinion of an expert in our own specialty, in matters surgical we have only a superficial general knowledge. Surgeons, however, have been accustomed for generations to dictate the agents and methods whereby their patients should be anaesthetized; even though in this matter it is they who have the superficial general knowledge whereas the anaesthetist is entitled to the opinion of an expert.

A request for the services of any professional anaesthetist is a professional consultation. Even though the surgeon may originally have been called into consultation, from the point of view of the anaesthetist subsequently called in, the case is in the surgeon's charge. The recognized rules governing consultation and its ethics are perfectly applicable to this situation. The consultant proffers advice as to the management of the case and may offer to apply the treatment he recommends. If the person in charge of the case disagrees with the wisdom of the advice the consultant has no alternative but to withdraw from the case.

There is no reason why we should all agree in opinion on matters about which the greatest experts disagree. No man should be forced to do something which he believes is wrong: if only because he is likely to do it badly because he believes it is wrong. The motto of William of Wykeham—"Manners makyth man"—has but gained in force in the seven intervening centuries; and good taste and intellectual humility are often as important as profound knowledge in professional relationships.

#### CONSIDERATION FROM SURGEON

The degree of consideration with which we are treated by surgeons will probably be the reciprocal of the consideration we exhibit in matters surgical. We must learn to "live and let live" by giving proof of our ability to understand and not to interfere in matters outside

our special field. If we adhere rigidly to this resolution we may reasonably expect a reciprocal freedom from interference by surgeons in matters pertaining to anaesthesia. Surgeons, after all, are reasonable human beings, and they chiefly desire good and safe anaesthesia for their own purposes. If they find that this usually results from leaving the anaesthetist to make his own decisions, they are likely to pursue this course.

Personal friendship between men working together is highly to be desired. Armies are keenly aware of its importance to that state of mind which they call "morale"; and every coach tries to foster an atmosphere of true fraternity in a team. Since the life or well-being of a patient is at stake the "morale" of the operating team is of the highest importance, and this depends to a large extent on the "atmosphere" which prevails between its two principal members: the surgeon and the anaesthetist.

No less must the anaesthetist win the respect of his other colleagues on the staff by the soundness of his opinion when consulted with regard to prognosis or to diagnostic or therapeutic measures. In these activities he should remember that evidence in writing is far more valuable than an ill-remembered verbal statement. He should punctiliously record what he has found and what he has done; on a patient's notes in a hospital, or in the form of a letter to the colleague who consulted him in the case of an ambulatory patient. As the passage of time renders the recollection of detail nebulous such notes are of inestimable value in establishing the facts.

#### IMPORTANCE OF DETAILS

Genius has been defined as "an infinite capacity for taking pains", and the third personal quality of the anaesthetist which is of vital importance is his inclination to pay minute attention to small details. He should early school himself to meticulous punctuality. Neither surgeons nor patients should ever be kept waiting: least of all the latter when they are already unconscious. In matters operative, speed is always desirable though haste is never justifiable because it is almost certain to engender difficulties and dangers.

Thus, since certain important preparations must be made, the anaesthetist should arrive in the operating room half an hour before the operation is due to begin. This will permit him to apply the mask or to insert the needle within a few moments of the arrival of the patient; and he can be sure that anaesthesia will be adequate for the start of the operation at the time arranged.

Since the surroundings of an operating room are not conducive to the patient's calm the less



time he is given to assimilate them the better. Noise of any sort is disturbing to a conscious patient and may be the cause of violent struggling in a patient partially conscious. It can rarely be avoided in the operating room itself for it is necessary that instruments be moved and hands be scrubbed, and some talking is inevitable. Moreover in these days of closed apparatus, bags, and spirometers we forget too easily that the use of our ears can provide us with most valuable information of minor degrees of respiratory obstruction or of the course of a tube in the hypopharynx.

A wise anaesthetist will therefore usually strive to perform induction of anaesthesia outside the operating room itself, and will only bring in the patient when he is satisfied that anaesthesia or analgesia is sufficient for the start of the operation.

#### EQUIPMENT

The upkeep of the armamentarium of a modern anaesthetist demands considerable time and work. Many things have to be cleaned and kept in good condition. Flowmeters and laryngoscopes are notoriously susceptible to minor derangements of function. In many hospitals this work is left to orderlies or nurses, who, however good their intentions may be, can not rival the intimate knowledge of the man who uses these things constantly. We all know the apparently malignant agency which seems to ordain that it is always at the critical moment that the laryngoscope fails to light, the oxygen cylinder is empty, or the needle proves to be blocked!

To all of us, especially in these busy days, time is precious. Nevertheless I believe that the man who is willing to do these necessary minor chores for himself is spending time wisely and well; and that the consequent rarity of these incidents, which can ruin an administration, will amply reward him for his attention to detail. Although these may be minor matters they are to me of such importance that I have always owned most of the apparatus with which I work and have looked after it myself. If I ask anyone else to do so, the request implies a high degree of trust in him! To me the time and labor involved represent a wise expenditure which has amply justified itself.

It has been stated that the anaesthetist should have made up his mind beforehand how to conduct the case. It is, of course, true that at any time mechanical difficulties or certain signs which may appear may cause the original intention to be modified to suit abnormal circumstances. This fact, however, does not absolve an anaesthetist of the responsibility to reach a definite decision. Indecision is always dangerous for it involves a vacillating and inconclusive state of mind. It is one thing to decide

to wait another five minutes, when in doubt, and then evaluate the position afresh. It is quite another to fail to reach a conclusion and, in a vaguely hopeful spirit, to allow matters to drift.

If these preliminaries have been observed, a calm and confident patient, who has received appropriate medication at the right time, arrives punctually in a quiet room where an unhurried anaesthetist, properly equipped with instruments in good condition, and a record sheet complete in detail, awaits him and is ready at once to start the administration. The foundations of a successful administration of anaesthesia have then been well and truly laid.

#### PRELIMINARY MEDICATION

We must now consider the technical factors which influence the success of the administration. Of these the first is preliminary medication, whose administration has been judicious in quality, quantity, and timing. Preliminary medication has three purposes: to diminish the secretory activity of the respiratory tract, to provide both psychic and somatic sedation of the patient, and to reduce the excitability of certain reflex paths. Inhibition of secretion is achieved by the use of atropine or scopolamine, and this effect is usually at its height 45 minutes from the time of injection. If either drug is to be used alone this is the best time for its administration.

Excessive secretion of mucus, which is most marked in children, is a frequent cause of unsatisfactory anaesthesia. The mucus itself constitutes a serious obstruction to the patency of the airway, and in light planes of anaesthesia it frequently irritates the vocal cords and gives rise to spasm of the glottis.

Scopolamine is nearly twice as effective as atropine in the same dosage. In either case we tend to administer too little. Any adult will tolerate 1/100 of a grain of atropine, and some workers have been in the habit of giving 1/60 of a grain to a healthy man. In the case of scopolamine 1/150 of a grain is probably a sufficient dose. Scopolamine produces euphoria whereas atropine does not; and it is a drug which requires careful preparation and which soon decomposes when stored. It is probable that impurity of the drug is responsible for most of the cases in which scopolamine has provoked untoward effects.

Both drugs have an inhibitory effect on the parasympathetic fibres, and for this reason many authorities feel that they should always be used before the administration of chloroform, ethyl chloride or cyclopropane. They should reduce the activity of those fibres of the vagus nerve which are inhibitory to cardiac action, and antagonize the embarrassing effects of cyclopro-

pane (such as spasm of the bronchioles or glottis) which are said to result from its stimulatory effect on the parasympathetic system.

Nitrous oxide is the only agent administered by inhalation which does not usually excite an increase in salivation, and it is most effective when administered to patients whose metabolic activity is low. Since neither atropine nor scopolamine depress the metabolic rate, and since, in this case, their drying effect is superfluous, this is the one occasion on which I do not care to use these drugs before anaesthesia by inhalation. In every other case I believe it is important that induction be preceded by atropine or scopolamine, given 45 minutes before anaesthesia is due to begin.

#### USE OF OPIATES

The opiates have enjoyed great popularity as preliminary medication because of their sedative effect. It is not usually realized that they also appreciably diminish secretory activity. Probably the most effective of them is Heroin, which unfortunately is not available in this country. Either morphine itself or one of the extracts of opium such as "pantopon" may be used. The chief disadvantage of these drugs is that they all diminish the minute-volume of respiration, and therefore render the exchange of gases in the lungs slower and less effective. To some extent this drawback can be mitigated by the proper timing of the injection, for the maximum depression of minute-volume is attained within an hour of administration and then begins to recede. The sedative effect, however, reaches its peak about 75 minutes from injection.

It is most unfortunate that these facts are not as yet fully recognized. In many hospitals induction is rendered most difficult for the anaesthetist because a patient has been given an injection of morphine about half an hour before he comes to the operating room. At this time the sedative effect is barely perceptible whereas respiratory depression is at its height. The latter can be minimized by the combination of atropine or scopolamine with morphine. These facts have been brought out by the study of the effects of these drugs on normal individuals by Wangeman and Hawk<sup>6,7</sup> and these papers deserve the careful attention of all anaesthetists.

#### BARBITURATES

The derivative of barbituric acid also depress respiration though their effect is less abrupt and more transient than that of the opiates<sup>7</sup> and can, in a similar way, be counteracted by scopolamine or atropine. They are hypnotic but not analgesic, and will therefore procure a placid and somnolent state in some patients. This effect is variable, for some patients exhibit a state of excitement and rest-

lessness. Experimental work<sup>8</sup> has suggested that the barbiturates increase the resistance of an individual to toxic manifestations resulting from the injection of a local analgesic; and many workers insist that their patients shall receive preliminary medication with a barbiturate before local or spinal analgesia.

Considerations of time forbid a more detailed discussion. We may summarize the question of preliminary medication by saying that:

(1) This administration is the first step of the subsequent anaesthesia, and the drug used and its quantity varies enormously with the agents and methods to be used for anaesthesia.

(2) Sometimes basal narcosis takes the place of preliminary medication. By this is meant the production of unconsciousness in the patient by the use of non-volatile drugs prior to the induction of anaesthesia. The drugs usually employed for the purpose are paraldehyde, rectal ether, tribromethyl alcohol or the barbiturates.

(3) Since it vitally influences the success or failure of the subsequent anaesthesia, the choice of drugs, their dosage, and the time for their administration should be left to the anaesthetist.

#### TECHNIQUE

Last, and by no means least, we must consider the technical factors during the administration which influence its success. During the century of our experience of anaesthesia great stress has been laid on the drugs with which the state is induced, and on the methods by which they are administered. Today I would ask you, as medical men, to examine the matter from a different angle. This is that the drugs which we already possess, and of whose properties we are aware, constitute an adequate armamentarium. For the shortcomings of anaesthesia it is we who are to blame rather than the agents. What we now need is not the discovery of new drugs, but more skill and knowledge in the use of those we already possess.

#### HYPOXIA

Two chief dangers beset the path of the anaesthetist. They are common to all anaesthetic agents and to all techniques. These are hypoxia and hypercarbia. The first term implies a reduction in the supply of oxygen to the patient. I use it in preference to the older term "anoxia" because it is accurate. Hypoxia signifies "too little oxygen", whereas "anoxia" connotes "no oxygen". The latter therefore describes a state which is not compatible with life and "this", as Euclid said "is absurd". It is an urgent need of animal life that oxygen be constantly taken in and carbon dioxide be equally constantly evolved. If either be interrupted for a short time death will rapidly ensue, for life depends upon a continual oxidative process.

The activities of an anaesthetist are directly



concerned with drugs and methods which profoundly influence this process. Where his efforts have led to death or grave complications it has usually been so because he was insufficiently conscious of this need. The agent or technique has been merely incidental.

Please note that I do not confine these remarks to anaesthesia by inhalation: they are applicable with even greater force to intravenous anaesthesia and spinal or regional analgesia. When one of these three is in use persons unaccustomed to giving anaesthetics are especially prone to overlook these vital necessities. They assume that if a drug is placed in vein, cerebrospinal fluid, or tissue the great advantage is that one need pay no attention to the ventilation of the lungs.

This is nevertheless quite as important in such cases as when an agent is administered by inhalation. Moreover, when such methods are used a certain dose of a drug is placed in a position from which it can not be recovered. If the dose proves too great the anaesthetist can only maintain the function of respiration until the body has detoxified the drug. Circulation, although it can be stimulated, can not be maintained artificially, and therefore if the overdose is sufficient to paralyze circulation the patient will die.

There are two chief causes of hypoxia. One is depression of respiration; the other is obstruction of the respiratory passages which are referred to generically by anaesthetists as "the airway". Depression of respiration is usually due to the injudicious administration of drugs, although in rare cases it may result from disease.

Of all the volatile and non-volatile substances which will produce unconsciousness, nitrous oxide and ethylene are the only ones which do not depress respiration. By "depression" I mean the reduction of the minute-volume of respiration so that the exchange of gases is decreased. Either the rate or the tide of respiration, if observed alone, is a fallacious guide to exchange, for this depends on both. It matters not whether a patient breathes 500 cubic centimetres 20 times a minute, or 250 cubic centimetres 40 times a minute, for the exchange or "minute-volume" is identical.

Although anaesthetists commonly record the rate of respiration, it is equally important to be conscious of the respiratory excursion. Ether has the peculiarity that it is a respiratory stimulant in light planes of anaesthesia, though it depresses exchange in the deeper strata. Indeed, any agent which can cause paralysis of the intercostal muscles will produce respiratory depression. This becomes obvious if a spirometer is used instead of a breathing bag, for, as the third plane is reached, respiratory excursion is found to decrease. Thus, when air

is the vehicle of the anaesthetic agent, anaesthesia in or below the third plane of the third stage must of necessity involve hypoxia.

I would like to stress this because it is such a common mistake in the administration of ether by open methods. It seems to be generally assumed that because air can freely enter the gauze the patient must have access to an adequate supply of oxygen. This is only true if respiratory exchange is of normal volume. Do we not all know that if patients, especially those who have received morphine beforehand, are really deeply anaesthetized with ether on an open mask they readily become cyanotic?

The lurid picture usually painted in pharmacological textbooks of a patient in "the stage of overdose" is based on the experience of laboratory workers who usually anaesthetize an animal in this way. The dangers which they attribute to deep anaesthesia with ether—the cyanosis, the widely dilated pupil which does not react to light, the progressive circulatory failure—are the outcome of hypoxia and not of deep anaesthesia. This difficulty is readily overcome by adding oxygen to the vapor beneath the mask. If this is done the dangerous symptoms do not appear even when the respiration fails from overdose of the agent. The secret of the efficient administration of ether lies in securing full oxygenation of the blood at all times.

#### THE DANGERS

I can not enter here into the perennial controversy which rages about the safety or danger of the impotent agents such as nitrous oxide or ethylene. This much, however, is certain: that the danger with them is that of acute hypoxia whereas with the agents of full potency it is chronic hypoxia. The latter is the more insidious and it may well be that a robust individual can tolerate a short period of acute hypoxia more easily than a long period of chronic lack of oxygen.

Agents such as chloroform and cyclopropane, which depress respiration without stimulating it in the early phases (as does ether) require very skilful and subtle administration. If a relative overdose occurs early in anaesthesia respiratory depression is prone to result, and the decrease in exchange may make it impossible to reach deep anaesthesia by means of the patient's own respiratory effort. For this reason extreme conservatism of dosage should govern the use of opiates or barbiturates as preliminary medication, and every effort should be made to avoid a relative overdose of the agent.

The recognition of hypoxia is greatly facilitated by keeping a chart of serial readings of blood-pressure and pulse-rate. When it is



found that both systolic and pulse-pressures as well as pulse-rate show a progressive increase the anaesthetist should suspect that hypoxia is their cause. The hypothesis can at once be verified or disproved by adding more oxygen to the mixture being inspired by the patient, and watching the effect on these signs.

The other chief cause of hypoxia is obstruction of the airway. Of this the commonest causes are: an excess of mucus, mechanical obstruction by the tongue (which, when relaxed, falls backwards against the posterior pharyngeal wall), and spasm of the glottis. The first two are so familiar that they need not be dwelt upon. Smooth administration after proper preliminary medication is the solution to the first, and a pharyngeal airway of appropriate size, and adequate support of the mandible, of the second.

Glottic spasm, however, may be caused either by something pertaining to the anaesthesia, or by surgical stimulus in anaesthesia which is, relatively, too light. In the first variety the spasm may result from the irritation of foreign fluids touching the vocal cords, or from the exhibition of too great a concentration of a pungent vapor. The solution to these is obvious. Reflex glottic spasm—the variety caused by surgical stimulus—is a more serious matter. It can be prevented either by anaesthesia sufficiently deep to abolish the reflex before the stimulus is applied, or else by endotracheal intubation. Since this matter has been fully discussed in my book<sup>9</sup> and elsewhere<sup>4</sup> it will not be dwelt upon here. Nor shall I elaborate the statement that rigidity of muscles is enhanced both by hypoxia and by hypercarbia.

#### HEAVY SEDATION

Any form of spinal or regional analgesia, as we all know to our cost, demands heavy sedation with non-volatile drugs to ensure its consistent success. To most normal people, it is a severe ordeal to remain conscious during an operation; for, even if analgesia is perfect, it is uncomfortable to lie motionless for a considerable length of time on an operating table whose upholstery leaves much to be desired.

Any person's ability to use regional analgesia wisely and successfully is increased an hundred-fold if he has ever undergone such an experience himself. A medical person's knowledge of what will be done to him at least saves him from the terror of the unknown which besets the layman. Even so, the results of the abolition of the sense of pain while the other senses remain intact are so strange that they have to be experienced to be understood.

Thus the patient during regional analgesia is almost always in a state of relative respiratory depression because of the sedative drugs which he has received. There is always the danger that he may develop a mechanical ob-

struction to respiration, or that he may vomit and require removal of the vomitus. Moreover oxygen in excess is the first and most important need should he show any of the signs of a toxic reaction to the analgesic drug. A person skilled in these matters should therefore always watch over such a patient and be ready to treat any untoward symptoms or signs.

The barbiturates, especially when given intravenously, depress respiration sharply: indeed this is the most intense and sudden form of depression commonly seen during anaesthesia. It is fashionable nowadays to administer morphine before the use of pentothal<sup>10</sup> and some workers like to use a barbiturate of short action, such as Nembutal, given orally. This, as Lundy<sup>11</sup> pointed out in his original paper, is superfluous, for pentothal is of ample potency, whereas evipal is not.

Nine years' experience has also confirmed the truth of his statement that preliminary medication with atropine is desirable. The glottis appears to be highly irritable during anaesthesia with pentothal, and if mucus touches the cords it may set up a spasm which will lead to hypoxia. Before anaesthesia with pentothal, therefore, morphine should be used sparingly if at all, whereas atropine or scopolamine in effective doses is indicated. In the case of evipal, which is less potent of action, fairly large doses of morphine as well as atropine or scopolamine are usually necessary.<sup>12</sup> So important is attention to the patency of the airway and the treatment of respiratory depression during intravenous anaesthesia that many authorities feel that two persons are required to conduct such a case properly.<sup>13</sup>

I submit to you that a lack of oxygen is the gravest and most dangerous insult to which the body can be subjected during anaesthesia, and that it can occur equally easily no matter what agent or technique is in use. It is far more important that an anaesthetist should avoid this than that he should use any particular drug or method. If we strive to become more acutely conscious of disturbances of respiratory function, by careful observation and meticulous recording of details, experience will soon teach us by what means we can best avoid them.

#### HYPERCARBIA

In all circumstances in which alveolar ventilation is impaired, not only will insufficient oxygen reach the blood, but carbon dioxide will be inadequately eliminated. One is as necessary to life as the other. While it is true that carbon dioxide, in the concentration in which it is normally present in the healthy conscious individual, is the chemical regulator of respiration, it is also known that in excessive concentrations it has certain toxic effects.

For many years there was a widespread ac-

ceptance of the view of Yandell Henderson<sup>14</sup> that a reduction of carbon dioxide could cause a condition of circulatory collapse. It is true that a patient can, by voluntary hyperventilation, induce a state of alkalosis resulting in tetany.<sup>15</sup> On the other hand it has been shown<sup>16</sup> that patients can be subjected to deliberate, extreme, manual hyper-ventilation of the lungs through a canister of soda-lime without harmful results.

#### THE DANGER

The danger during anaesthesia is hypercarbia rather than hypocarbia. We forget too easily that the placing of any object over the face will, to some extent, hinder the escape of carbon dioxide. All of us who must wear masks over our faces for some hours at a time must inevitably breathe a concentration of carbon dioxide slightly higher than normal. Perhaps this state of hypercarbia is responsible for some of the irritability and hypertension sometimes in evidence among members of surgical teams!!

When a rubber anaesthetic mask is placed upon a patient's face, the "dead space" of his respiratory passages is always augmented. This is why, even when the "absorption technique" of anaesthesia is in use, analyses show about 3 per cent of carbon dioxide under the mask;<sup>17</sup> whereas air contains only .05 per cent of the gas. When, in addition to this, respiration becomes obstructed or depressed, not only does oxygen fail to get in, but carbon dioxide accumulates in the "dead space" of the respiratory tree. Even though a canister full of soda-lime be in use, if the tide of respiration decreases there will come a point at which the movement of the gases is insufficient for them to come into contact with the absorbent.

When other techniques are in use the likelihood of hypercarbia is greater. An open mask, provided that it is literally "open" is perhaps the safest method, for carbon dioxide can usually leak out between the mask and the face. But if several thick towels are wrapped round the mask this does not occur. Indeed inept administrators have been known to cover up a supposedly open mask so tightly that asphyxia as well as hypercarbia has supervened.

Probably the "semiclosed" technique, in which rebreathing occurs and the last part of expiration is expelled through a valve placed close to the face, is most easily abused in respect of hypercarbia. Unless fresh gases enter such a system at a rate at least equal to the minute-volume of respiration, a dangerous concentration of carbon dioxide will occur. Flows of from six to ten litres a minute are extravagant when maintenance over a period of hours is necessary, and many a patient has been subjected to a toxic concentration of carbon dioxide to satisfy the inclination to economy of the anaesthetist.

Hypercarbia and hypoxia usually co-exist be-

cause both spring inevitably from the same causes. Anaesthetists, as a rule, are more alive to the latter than to the former. Nevertheless hypercarbia can exist in the presence of full oxygenation. If, for instance, one litre per minute of oxygen and a similar amount of nitrous oxide are allowed to flow through a "semiclosed" system, a patient breathing vigorously will show signs of hypercarbia in a few minutes even though he be unquestionably well oxygenated.

The signs recorded on the chart will not help us to distinguish between the two conditions, for they are identical with those already described for hypoxia. The only minor difference is that in hypoxia the respiratory rate tends to increase whereas in hypercarbia the increase is rather in volume than rate. The only way in which both evils can be avoided is for the anaesthetist to be constantly on the watch for either, and to be able to visualize the physiological consequences of his activities. When in doubt, as one often is, one should modify the conditions which may be causing the anomaly, and note the results of the change.

It is also well to remember that all the anaesthetic drugs tend to raise the threshold of the respiratory centre to stimuli. For this reason abnormal signs may either not appear until the condition is fairly advanced or they may be completely masked and not appear at all.

All anaesthetic agents are dangerous in one way or another. Not one of them is entirely safe. Each has its own peculiarities: its advantages and its drawbacks. When harm befalls a patient it is more commonly due to the aphysiological use of a drug than to the properties of the drug itself. It is only the individual user who, in a given situation, can tell how best to meet it. The vital thing about an administration is that it should be smooth and that it violate the integrity of the circulatory and respiratory system as little as may be possible.

#### IMPORTANCE OF RECORDS

We are all familiar with the old gibe levelled at our surgical colleagues that "the operation was a great success but the patient died". We may be able to achieve good anaesthesia as it has been described up to this point, but if our ministrations are to be really successful we must be sure that they do not engender disastrous sequelae.

The vital importance of keeping accurate records has already been stressed, both as regards the condition of the patient before operation and as regards his behaviour during it. Unless, however, we keep equally detailed records of his condition from operation to discharge from hospital we can never have any evidence on which to found arguments for or against any given drug or method.

This has been one of the greatest handicaps



of anaesthesia in the past: that so few men were prepared to undertake the necessary labor of watching the convalescence of their patients and recording the complications which occurred. The result is that men speak glibly enough from memory, for they have rarely had the opportunity to compare their recollection with the facts. I, who have had this opportunity, know that my estimate of any particular number of cases, made in perfectly good faith, usually proves to be about double the actual figure when this is ascertained. The results of anaesthesia have been obscured by a plethora of opinion and a paucity of fact. This situation must be corrected if we are to learn.

It is not my function here to enter into the details of how such records are kept, and of how, by means of one or another mechanical system, the facts become readily accessible. I believe, however, that the American Society of Anaesthetists has done great service by standardizing a code, and by making the Hollerith system available in this way to anaesthetists who wish to use it. Those who are interested in this matter should read certain papers by Rovenstine,<sup>18</sup> Saklad,<sup>19</sup> and Nosworthy,<sup>20</sup> and the mimeographed matter issued by the Committee on Records and Statistics of the American Society of Anaesthetists. If we do this there will accumulate, as the years pass, evidence of the success or lack of success of our work.

By means of the Hollerith system all the pertinent facts of a case can be recorded. When sufficiently large numbers of such records are available it is possible to perform a true statistical study. This involves a comparison of results in cases in which every variable is identical save the one under investigation. If a reasonable number of cases of each kind, selected thus at random, can be provided, a skilled mathematician can tell, by mathematical tests of probability, to what extent the difference in result was due to fortuity, and to what extent to the particular factor in question. Eisenhart<sup>21</sup> recently used our cards to demonstrate how this is done, and I recommend to you this example of method, even though the results, in this instance, are not of especial interest.

The day is approaching on which we shall have accumulated sufficient records to be able to advance definite evidence, as distinct from opinion, as to the advisability or otherwise of many things which we do.

Let us therefore set high the ideal of success at which we aim. Perfection is thought by philosophers to be supra-human and therefore unattainable. This reflection should help to keep us humble, and, if we remain critical of ourselves, our performance will improve. In this way we shall progressively approach nearer

our ideal, which should never be less than perfection itself.

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#### Sincere Effort Needed

Experiences like this may seem extraordinary. The author believes they appear so only because there has been no great drive to uncover tuberculosis in hospital personnel. There can be no cause for the hesitation on the part of the general hospital to put its house in order with regard to tuberculosis other than inertia and the fear of administrative commotion.

A painstaking design and observance of rules governing the diagnosis and isolation of the disease in patients and employees will make it possible with safety to admit tuberculous patients to general hospitals. There is no reason why all this can not be accomplished by voluntary efforts. It is obvious from our newer experience with tuberculosis that such hospitalization is one of the great necessities to achieve the basic aim of all medical endeavor—the saving of human life.—Tuberculosis Control in Hospitals, Robert G. Block, M.D., The NTA Bulletin, Aug., 1944.

# Treatment of Fractures In Relation To Functional Result

EDWARD HARLAN WILSON, M.D.

MODERN fracture treatment is generally considered to have begun when the use of the roentgen ray, in connection with the treatment and diagnosis of fractures, became general. As the general use of X-ray did not begin until about 1905, only a brief period of time elapsed before World War I occurred, with its mass demands for treatment of every conceivable type of fracture injury. Since fracture treatment had developed on an individual basis, the War served to simplify and standardize the individualistic methods which had been in use.

At the beginning there was great demand for a multitude of fracture splints and the Army Medical Service quickly simplified this problem into the use of standard Thomas traction splints for arm and leg. The permanent contribution of the experience in that War was the development of skeletal traction in the treatment of shaft fractures and, secondly, thorough débridement in the treatment of compound wounds. It was the first great war in which limbs were saved and the matter of fact business of saving them left little time to consideration of functional problems.

Men returning from war service after peace had been established brought war methods into the peacetime practice of fracture treatment. Skeletal traction continued to maintain its position during the years between World War I and the present war. The treatment of compound wounds went through an interesting period of evolution. This began with the abandonment of attempts at chemical sterilization of wounds and the substitution for it of aseptic cleansing by means of soap and irrigation. This in turn was abandoned by many in favor of the Orr treatment which consisted of packing the wound with vaseline gauze together with thorough splinting of the part by plaster of Paris while at the same time sealing in the wound to prevent meddlesome dressings. This method was found to be extremely useful in the Spanish Civil War and has been continued through the present war, modified by the use of sulfanilamide powder in the wounds and by oral administration.

In the peace years, as experience increased in the use of skeletal traction, certain unfavorable complications were noted. It was found that there was a definite increase in the occur-

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rence of delayed union and non-union, especially in fractures of the arm and lower limbs. This was due to the effect of over-pull or distraction. Likewise, it was found that traction did not always produce the alignment desired, and frequently the position obtained was, while far from ideal, considered sufficiently good.

In fractures of the upper third of the femur particular trouble had been encountered in aligning the parts. The adductor muscles tend to pull the lower fragment upward and inward while the abductor muscles, which attach to the upper fragment, tend to hinge the upper fragment outwardly, thus bringing about a wide separation. Closed reduction with plating of this fracture was very likely to end in angulation because of the strains placed upon the screws which held the plate in place. Such fracture, on the other hand, will align satisfactorily as a rule if the leg is placed in abduction with extreme outward rotation, either with or without open reduction as the necessity may be.

In the humerus even two or three pounds of traction was found to produce distraction. Böhler, who became a great advocate of skeletal traction and counter traction of fractures of the forearm, later abandoned the method entirely because of the frequency of non-union, and substituted for it a method of manual reduction and pull which has been quite satisfactory. There has also been belief that fractures of the femur under skeletal traction have tended toward delay in union and to an increase in percentage of non-union.

## WAR'S LESSONS

With the occurrence of the present World War as a laboratory for mass study of methods of fracture treatment, came the early realization that functional results of fractures were frequently very bad. By this I mean that function was either too long delayed or that full functional recovery failed to develop in a fairly large

Presented at the Third General Session, Ninety-Eighth Annual Meeting of the Ohio State Medical Association, May 2-4, 1944, Columbus.



percentage of fractures. Thus, before our entry into the war, the Royal Army Medical Corps of Great Britain had found that with the ordinary methods of treatment not a single case of fracture of the femur had been rehabilitated back into active service by the end of one year from the time of injury. Peacetime record will, of course, show a better average than that of wartime due to the much greater extent of soft tissue injuries which accompany compound fractures from war causes.

At the same time, reviewing a series of simple fractures of the femur treated in peacetime, one is struck by the extremely poor results in motion of the knee. Knee motion probably constitutes the most severe challenge now made to the methods in use for treatment of this lesion. It is of interest to note the early realization of the need to improve functional results. It is not beyond reason to hope that the experience of World War II will contribute permanently something of value toward directing fracture treatment to those methods which will most satisfactorily bring about satisfactory rehabilitation of the individual.

#### THE KNEE

In considering the problem of the stiff knee which so commonly follows fracture of the femur there is ample evidence to indicate that the principal cause is damage to the extensor group of muscles of the thigh with formation of dense scar tissue and adherence to the anterior surface of the femur. Attack is being made on the problem first by choosing those methods of treatment of the fracture most conducive toward maintaining some motion of the knee during the period of fixation while at the other end of the problem, Colonel T. Campbell Thompson of the Army Medical Service has approached the problem from the viewpoint of excision of the scar and freeing of the extensor muscles in an effort to correct the condition once it has occurred. There is considerable promise in this effort but it is yet too early to judge of its results in a large number of cases.

From the viewpoint of treatment there are three points of attack in relation to the problem under discussion. First, the use of skeletal traction in connection with a flexed knee splint, such as the Pearson attachment to the Thomas splint, and the maintenance of passive and active knee motion throughout the period of splinting, by means of balanced suspension. This is the oldest method available and is sometimes defeated because of pain resulting from motion at the site of fracture.

Secondly, there is an increasing tendency toward open reduction with internal fixation, followed by early motion which is dependent

upon the solidity of fixation at the fracture line. Dr. Clay Murray of the Presbyterian Hospital, New York, has for some years used this method in selected injuries. There can be no doubt that there is an increasing tendency toward open reduction by competent surgeons. This has been permitted by the safety margin which has resulted from the local and general use of sulfanilamide while at the same time the development of non-irritating metals has further contributed in lessening the danger of local irritation. The danger attending its use is the difficulty in determining how much strain the fixation at the fracture line will permit.

Murray believes that open reduction, if it is to be carried out, should be performed within 24 hours wherever possible. He points out that absorption of the fracture margins may begin very promptly and in late open fixation, in the face of an increasing absorption, the fixation plate may only serve to confirm a gap which will in some cases develop if absorption continues. He believes that early fixation with impaction of the fragments prevents such absorption by restoring the demand for skeletal support.

#### METHOD OF ANDERSON

The third method now being used to combat knee stiffness is the use of the so-called half pin methods as exemplified by the Roger Anderson, Stader, and similar apparatus. The reports on these methods are conflicting. The Army Medical Service looks upon them with disfavor due to the occurrence of localized osteomyelitis at the points where the pins enter the bone substance. On the other hand, those who have used the method constantly tend to be enthusiastic in their praise and it is difficult at this time to reconcile these extreme views.

The Roger Anderson method was introduced into Great Britain in 1940 by the American Hospital in Britain which had a record of about 350 cases of fracture of the femur, many of them compound, so treated. During that time no serious infection at the site of a pin developed at any time, and the functional results were excellent. In a great many cases, knee flexion at the end of one year was better than 90 degrees. The Army, on the other hand, can show a large series of X-rays demonstrating the occurrence of bone abscesses at the pin sites.

In favor of this method of treatment is the fact that it does maintain the reduction position while permitting motion, thus greatly shortening the occupation of a hospital bed and contributing to the general welfare of the patient, who is up and about, bearing weight on the limb. Secondly, it has the benefit of skeletal traction, while at the same time permitting constant readjustment of the contact of the fractured ends,

thus effectively combatting distraction. If a space develops it may be immediately closed by simple readjustment of the apparatus.

The disadvantages are that generalized use in the Army has resulted in a large percentage of localized bone infections. In the femur the upper pin almost always causes pain because of the amount of motion necessary in the muscles of that region while active, while in some cases the same is true of the lowest pin.

Functionally, the method permits use of the limb in a fairly normal manner together with about 25 degrees of active flexion. More than this is not to be expected during the period of treatment because of the penetration of the vastus externus by the lowest pin. The universal experience is, however, that once healing has occurred and the pins have been removed, knee flexion increases rapidly in the succeeding months due to the maintenance of partial motion during the time of treatment.

#### IMPORTANCE OF PERSONALIZING

One further comment should be made. None of the forms of this type of apparatus should be regarded as automatic, accurate machines of reduction. On the contrary, reduction may be extremely difficult and tedious. I can recall one patient who had to have 26 series of X-ray plates before the desired position was obtained. I personally consider the apparatus as a method of retention rather than one of reduction and have used it in connection with open reduction, or with other methods of manual or skeletal reduction.

The individual who has had a long period of delayed union or perhaps non-union, including many months of splinting in one form or another, is an especially fit subject for the use of the half pin method if a secondary bone graft has to be performed. Use of plaster as a retention method in any of these long continued cases would lead to almost irreparable stiffness of the knee.

Certain points of technique should be emphasized. The half pins must engage both cortices, otherwise the pin will not be firm and will work back and forth and is bound to cause local irritation. This is, I believe, the cause of some of the local bone infection complained of. This is particularly true of the upper and lower pins. Secondly, the fractures must be frequently X-rayed to correct any distraction that may occur during the course of treatment. Lastly, the patient must use extreme care to prevent any individual or object from bumping into the apparatus on the side of the leg. In the only case of pin infection that I have seen, the pin became painful after such injury and subsequent operation disclosed that the force had been

sufficiently severe to completely fracture a portion of the cortex adjacent to the pin which thus resulted in free motion at the pin site.

#### SHORTER TIME

During the past 20 years there have been improvements made in the treatment of various other fractures which have greatly shortened the period of functional recovery and have made that recovery more certain. Nailing of fractures of the neck of the femur with freedom from splinting has led to complete functional and anatomic recovery in over 70 per cent of treated cases. Emphasis should be made on the importance of repairing these fractures during the first 24 hours after occurrence. Absorption of the neck from disuse probably begins almost immediately. Fixation in the correct anatomical position restores the functional demand for support and probably has direct influence on the problem of bone absorption. Fractures which have existed for from 10 to 14 days should be considered as potential non-unions and reconstructive procedures should be carried out at once.

Open fixation of fractures of the trochanter marks a further advance in the treatment of an aged group of patients. While these fractures will unite with almost any form of treatment, the ability to begin movement immediately after open fixation results in a quick return of function in the limb and also prevents degeneration of the general health from prolonged recumbency in bed.

Fracture of the neck of the humerus, under the older treatment of prolonged splinting with the arm frequently in the position of abduction, often failed to attain satisfactory reduction and resulted in universal and prolonged stiffness in the shoulder region. This has been generally replaced by the method of manipulating the upper arm much as though there were a dislocation present. Usually this will result in perfect anatomical reduction even when there is an associated dislocation of the head. An impacted fracture is the result and, just as in impacted, undisplaced fractures, early active motion may be begun in a few days. If the treatment is properly carried out most of these individuals will show a fairly normal range of motion within six to seven weeks after injury.

Fracture of the patella, which used to offer so much difficulty and much uncertainty as to both the anatomical and functional results, has been converted into a lesion in which functional recovery has been made certain and the period of recovery vastly shortened. The preferred method of treatment is to remove one of the fragments or, in case of a greatly comminuted fracture, all of the fragments except one large one. If the remaining portion is attached to



the quadriceps then the patella ligament is sutured into the same fragment with heavy braided silk, whereas if the lower fragment is preserved, the quadriceps tendon is the subject of suture. A cast is then applied for two weeks and this is followed by one week of gradually increasing use of the knee while remaining in bed.

At the end of three weeks the patient is permitted to be up and about and is educated to perform active exercises designed to rapidly bring back full function of the knee. Ninety degree flexion is usually present within six to seven weeks after injury. The old method of wiring or otherwise fastening the fragments together required prolonged splinting and often failed to bring about union of the fragments. Stiffness of the knee persisted for many months and, if union did not result, permanent limitation of motion ensued. Fractures of the olecranon with fixation by open reduction again permit early motion and consequent early return of function.

#### ADJACENT TO A JOINT

Fractures close to or involving a joint will continue to require splinting. Open reduction, when feasible and where found to be necessary, will often permit a shortening of the period of immobilization and earlier return of function. Fractures close to the wrist joint require anatomic reduction. We still see too many failures to maintain the position of ulnar deviation which, when neglected, always leads to an impaired function and deformed appearance of the wrist. I believe that some of these deformities result from imperfect splinting even though good reduction had originally been obtained. The persistent use of board splints or the failure to carry a plaster splint around to the median side of the hand and forearm is very likely to result in gradual loss of position. At least, I feel that emphasis on these points will result in uniformly better position and function.

#### THE RESULTS

In general, the better the reduction the more satisfactory will be the functional return but it is of equal importance to time one's reduction so that it does not bring about an increase in damage to the soft tissues in the region of the fracture and, above all, does not result in serious interference with circulation.

Immediate reduction of fractures of the lower end of the humerus in children is a frequent cause of Volkmann's contracture, and other changes in the forearm and hand. The use of the Jones position should not be instituted in the presence of marked swelling because damage results quickly and often can not be undone even when the elbow is straightened out within a few hours. It has been my practice to allow most elbow fractures in children to rest on a

pillow for a week and sometimes longer before attempting manipulation. The results have been uniformly good and it has not resulted in any delay in union or function.

Similar consideration should govern the time of manipulation or other treatment in serious injuries in the region of the ankle. The margin of soft tissue around the bones at this level of the limb allows very little room for soft tissue swelling and if swelling is hard and brawny, manipulation should not be carried out until the bones can be definitely palpated. When such fractures are treated prematurely one sees the familiar picture of blisters, intense swelling of the foot and sometimes temporary interference with the nerve supply.

Lastly, one must recognize that certain fractures which involve both the ankle and the knee joint can not possibly permit restoration of a satisfactory and painless range of motion. Many months of disability will be saved if, on recognition of this fact, prompt fusion of the joint is carried out. Arthrodesis of the ankle produces such a satisfactory weight-bearing foot that no real impairment results from the viewpoint of ability to work. Arthrodesis of the knee, on the other hand, does produce an awkward, impaired body and conservatism is warranted except in the most severe injuries with masseration of the joint surfaces.

#### COMPLICATION

A frequent and unwelcome complication of fractures of the wrist and sometimes fractures of the foot and ankle, is the occurrence of what is variously known as reflex atrophy, Sudecks' atrophy, or post-traumatic dystrophy. In spite of careful splinting, pain and swelling persist and are intense, often in the presence of relatively minor degree of bone injury. Gradually, pain spreads upward until it involves the shoulder joint. After a few weeks, stiffness is almost total in the fingers and hand and in the shoulder. Attempts at exercise, by means of physiotherapy or otherwise, result in agonizing pain. Not infrequently the patient gradually becomes semi-hysterical especially if he or she is accused of not trying hard enough to bring about motion.

This condition was first reported by Sudecks in 1900. DeTakats, in recent studies, has advanced the belief that the condition originates from injury to the nerves and perivascular tissues, which are rich in nerves, at the site of the fracture, causing an excessive number of impulses to ascend to the higher centers thereby resulting in continuous spasm contractures of the musculature of the limb. He believes that frequent early infiltration of the injured area with novocaine, repeated daily if necessary, will abort the syndrome. Once the condition has progressed,

local treatment will no longer improve the symptoms. Section of certain sympathetic ganglions in the cervical region will then bring about prompt relief of pain but not of the stiffness which has already become quite fixed. His work is interesting and offers a hopeful measure of warding off this very annoying complication.

#### REHABILITATION

Finally, a word should be said about rehabilitation of the individual once the fracture has become healed. Physiotherapy is a very useful measure in the transitional stage following non-use. Beginning movements are painful due to the positional contracture of muscles and to the fibrosis of soft tissues from injury to them at the time of fracture.

The essence of physiotherapy is to teach the patient to move the limb through a gradually increasing range of painless motion. If motion is begun gently and does not impinge on painful limits, the patient will rapidly gain confidence, increase his range, and become quite co-operative. If he is told simply to go out and begin moving his limb he will use it in an ungoverned manner which will cause sharp reaction of pain and muscle tightening. This is quickly converted into an exaggerated idea of guarding his limb from all motion.

Once physiotherapy has brought about a fair range of motion, exercises against resistance should be instituted to increase the power of the muscles. Once this stage has been attained, physiotherapy alone will not suffice and must be either accompanied by or supplanted by more active forms of activity. In the case of workmen it is especially important that employers take them back and furnish light, restricted work which will further aid the individuals in rapid restoration of ability to perform full duty.

#### SUMMARY

In summary I would like to emphasize the point that fracture treatment should always be based on the consideration of functional recovery and that those methods which are found to best promote such recovery should always be those chosen.

Finding a person with tuberculosis in the minimal stage means a large saving to the individual and to the taxpayer; for such a person may be treated with little or no loss of time. Usually his disease does not become contagious and, therefore, he does not spread it to others. Furthermore, he, himself, does not fall ill, and therefore, does not require a long period of hospitalization. —The Evolution of Tuberculosis by J. A. Myers, M.D., Minneapolis, Minn., 1944.

#### KEEPING UP WITH MEDICINE

THERE is a great deal of present day literature which places great emphasis upon psychology at the expense of physiology so one can even go back to one's boyhood days and regain the impression that a man's soul is something utterly detached from the body in which it resides. This neglect of physiological function and physical health offers a convenient avenue of escape for those who wish to give their imagination free wing to soar into the world of pure fancy and in so many very realistic essays about life we find a vast amount of very entertaining fiction. This accounts for the theories of the psychologists of the new thought who are uninhibited by our fleshly limitations. Surely psychological health rests upon physiological health. Function can not be normal as long as the organs concerned with that function are diseased. Anything, therefore, which causes organs to be diseased will cause organs to function. To assume that wantonness leads toward depravity is to ignore the fact that wantonness is natural and that depravity, therefore, must lie in the opposite direction.

\* \* \*

IT is interesting to speculate whether the proper attention will be given to sojourning at watering places in the restoration of our injured soldier. We, in civilian life, have never given the spas their rightful place in our society. Unquestionably, mineral springs offer exceptional advantages for rehabilitation. Personality and situation neurosis, both from military life and civilian life, respond favorably to the mineral water treatment, accompanied by physical therapy, regimented diet, and recreation. We ought to be giving some thought to the use of such institutions.

\* \* \*

THE search goes on for a menstrum which will give absorption and will not produce tissue changes. Pryson and Code have introduced beeswax as such a vehicle.

\* \* \*

CAREFUL blood examination should be undertaken on patients presenting certain of the more important criteria of blood disease such as enlargement of spleen or of lymph nodes, hemorrhage, mouth and throat lesions.

\* \* \*

THE diagnosis of occupational allergy dermatitis is made by considering the occupational history, knowing the sensitizing properties of chemicals encountered while at work, and the performance of patch tests.

\* \* \*

GREEN jaundice is much more often seen in patients with cancer.—J. F.



# Acute Obstructive Dyspnea

HOMER V. WEAVER, M.D.

**S**TENOSIS of the airway is a condition which I feel will be of interest to all of us who have the responsibility of treating it. Jackson<sup>1</sup> says that the mortality in these cases is dependent on our ability to recognize them and our judgment in handling them. He cites 126 cases in which the primary lesion was laryngeal obstruction with diagnoses of asthma in 34, pneumonia in 29, and paralysis of the diaphragm in one.

My interest in this subject has been stimulated by the problems in my own practice and a study of some of the newer methods of treatment.

The etiological diseases and conditions which cause obstructive dyspnea are many. A classification of the more common lesions follows:

## I. Infectious:

- A. Acute laryngotracheobronchitis.
- B. Diphtheria.
- C. Retropharyngeal abscess.
- D. Laryngeal abscess.
- E. Syphilis.
- F. Tuberculosis.
- G. Fungus diseases.
- H. Ludwig's angina.

## II. Noninfectious:

- A. Trauma:
  1. Foreign bodies.
  2. Mechanical—(a) Cuts, (b) Bruises.
  3. Gases—(a) Phosgene, (b) Chloropicrin.
  4. Caustics—(a) Lye, (b) Lysol, (c) Phenol.
  5. Reaction to X-ray.
- B. Allergy and Reaction to Drugs:
  1. Angioneurotic edema.
  2. Reaction to KI.
- C. Tumors:
  1. Intrinsic—(a) Carcinomata, (b) Sarcomata, (c) Fibromata, (d) Papillomata, (e) Cysts, (f) Lipomata, (g) Hemotomata.
  2. Extrinsic—(a) Thyroid enlargements, (b) Carcinomata, (c) Sarcomata, (d) Thymus enlargements.
- D. Systemic Diseases and Conditions:
  1. Nephritis.
  2. Cardiac failure.
  3. Myxedema.
  4. Toxemias.
  5. Malnutrition.

## The Author

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E. Congenital atresias.

F. Nerve Lesions:

1. Spasm.
2. Abductor paralysis.

## SYMPTOMS

The main symptoms of obstructive dyspnea are restlessness, stridor, increased respiratory rate, indrawing of the suprasternal notch, intercostal spaces and substernal regions associated with abnormal color varying from ashy gray to later cyanosis. These are not seen in pneumonia, asthma, mediastinal cardiac or pulmonary lesions unless complicated by laryngeal involvement.<sup>2</sup>

## DIAGNOSIS

The recognition of the degree of obstruction and the general condition of the patient are the first consideration in the proper handling of these patients. The history, physical examination and laboratory work, which are necessary to arrive at an etiological diagnosis, may need to be postponed if dyspnea is severe and a mechanical airway established.

The acute infections vary in their history, clinical behavior and physical findings.

Diphtheria is a disease of high toxicity and in which a pseudomembrane can usually be found in the nose or throat. It is accompanied by a moderate elevation of temperature and usually by asymmetrical glandular enlargement. There is a mousy odor present. The laboratory findings are important but frequently it is wise to give antitoxin before positive cultures for Klebs Loeffler bacilli are found. The incidence has been lowered to the point where there is danger of overlooking the cases that do occur.

Acute laryngotracheobronchitis is usually of shorter duration, frequently only 24-36 hours between the first symptoms and the onset of difficult breathing. The temperature is usually high. It is characterized by increasing swelling and inflammation in the glottic area, spreading downward by continuity and involving the trachea and bronchi with complicating mucous plugs and toxemia.<sup>3</sup> The predominating organism is strepto-

Presented before the Section on Eye, Ear, Nose and Throat, Ninety-Eighth Annual Meeting, Ohio State Medical Association, Columbus, May 2-4, 1944.

coccus but staphylococcus, pneumococcus and influenza bacillus are frequently found.<sup>3</sup>

There are many milder degrees of nonspecific acute inflammations and infections of the larynx causing some respiratory embarrassment and these have made a statistical study of acute laryngotracheobronchitis difficult and inaccurate.

Retropharyngeal abscess as a factor in obstruction usually occurs in children and is frequently not suspected until there is some difficulty in breathing. A swelling of the post pharyngeal wall behind the tonsil and to one side of the midline with fluctuation on palpation are the classical findings.<sup>4</sup> Stridor on inspiration alone may occur in this lesion.

Laryngeal abscess is usually secondary to some other infection in this area and frequently occurs between the epiglottis and hyoid bone but it may occur anywhere in the larynx.

Syphilis of the larynx may be a complication of congenital secondary or tertiary types. In the congenital types there is usually a uniform symmetrical infiltration usually without ulceration. In secondary lues a mucous patch may be located in the larynx with ulceration and swelling. Gummata may occur causing necrosis and swelling. Any of these types may lead to stenosis following scar tissue formation depending on their location and depth of involvement.

Tuberculosis may occur as a primary infection but it is usually secondary to pulmonary lesion. The parts involved and in the order of their frequency are the interarytenoid fold, vocal cords, arytenoids, ventricular bands and lastly the epiglottis. There may be ulceration and often dysphagia. The lesion is usually asymmetrical. There is usually not much obstruction unless papillomatous granulations form and encroach on the lumen of the larynx.

Fungal disease—Blastomycosis, actinomycosis and leptothricosis are rare lesions and can be diagnosed only by biopsy and by the finding of fungus in the tissue. They may be coincident with or be confused with syphilis or malignancy.

Ludwig's angina is characterized by an inflammatory wooden-like induration of the neck extending downward from the floor of the mouth. The swelling may involve the laryngeal area and cause obstructive symptoms.<sup>5</sup>

In the diagnosis of noninfectious causes, the history is helpful. Trauma from foreign bodies or following attempts at removal, gases, bruises, drinking of hot liquids or caustics may cause inflammatory reaction and associated obstruction.

Allergies must be suspected when the patient is known to have a sensitivity to foreign protein and when injections of bacterial proteins, pollens or animal sera are given. The formation

of antibodies is an allergic phenomenon so there is probably an allergic factor in all infections.<sup>6</sup> The Schick and tuberculin tests are based on this allergic sensitivity. Angioneurotic edema belongs under this heading although there are hereditary tendencies and sometimes toxic factors.<sup>7</sup>

Potassium iodide may cause inflammatory swelling in the larynx in patients sensitive to iodides.

Tumors and cysts and their malignancy or absence of it must be diagnosed by their appearance and biopsy. Thyroid enlargements may cause pressure on the larynx or may cause trouble by pressure on the recurrent laryngeal nerves. The role the thymus plays in sudden deaths has not been definitely determined.<sup>8</sup> Anesthetic deaths are frequently placed under this heading. X-rays of the thymus have been made routine for children in many reliable institutions before anesthesia is given.

Systemic diseases and conditions which may cause laryngeal swellings are nephritis, cardiac failure, myxedema toxemias and malnutrition. They cause swelling from different mechanisms. Nephritis and malnutrition are likely to be accompanied by low protein concentration of the plasma—in nephritis by protein loss and in malnutrition probably by low protein intake and associated vitamin deficiency. Sears<sup>9</sup> feels that edema can be explained largely on the basis of differences in colloidal pressure in the blood vessels and the intercellular spaces. He states that salt does not cause edema unless the plasma protein falls below 4 per cent and that if the kidneys are removed, edema does not develop.

Cardiovascular disease, toxemias and glandular diseases probably involve some other factors such as damaged capillary bed and salt concentration in addition to changes in plasma protein. Schemm<sup>10</sup> states that edematous fluid is high in salt concentration and is alkaline in reaction with a PH of 7.7. He feels that a high fluid intake as a solvent for the salt and the administration of dilute HCL or foods forming an acid ash are indicated together with a salt free diet.

Congenital atresias<sup>11</sup> may vary from webs, deformed epiglottides, to complete absence of lumen. Webs are not uncommon and are usually located at the level of the glottis. They may occur elsewhere and may be asymmetrical.

Nerve lesions—The most important nerve lesions are laryngeal stridulous and abductor paralysis. Laryngeal stridulous occurs mostly in children. There are frequently nutritional disturbances, enlarged glands and sometimes intestinal parasites present.<sup>4</sup> It is characterized by sudden crowing inspirations followed by apnea. The breathing usually starts again and is noisy at first but soon returns to normal.

Abductor paralysis may be caused by trauma



such as gun shot wounds, stab wounds, thyroidectomy, aneurism, thickened pleura, pulmonary tuberculosis, syphilis, pericardial effusion, dilatation of the left auricle, mediastinal tumors, adenopathy of Hodgkin's, neuritis from toxins of diphtheria, lead or others. Examination of the larynx and observation of its movements is the only method of diagnosis.

#### OPERATIVE

Treatment consists of first maintaining an airway. If the patient has extreme dyspnea and is in imminent danger of asphyxia some type of operative procedure is necessary. In diphtheria the O'Dwyer tube has been used quite successfully by many. It has the advantage that it can be introduced quickly, involves little shock and leaves no scars. It will not relieve obstructions above the larynx and there is some danger that it might be dislodged in the absence of a physician skilled in replacing it. There is also some trauma associated with its introduction and presence in the larynx. Antitoxin will usually improve the lesion so much that in the hands of a skilled operator it is quite satisfactory.

Tracheotomy is preferable for most other lesions requiring operative interference. It puts the larynx at rest, allows better evacuation of bronchial or tracheal secretions and relieves obstruction from any cause above the level of the tube. An ordinary tracheotomy with the tube placed low will lessen the complications and allow earlier decannulation. Many operators prefer to do the operation over a Mosher life-saving tube or bronchoscope in cases where the urgency is great. Experienced nursing care is necessary for good results. The inner cannula must be kept clean and the outer cannula changed daily. When mucous plugs are present saline instilled in the tube will help liquefy them and make their removal possible. Nasal gavage may be necessary if the pharyngeal muscles do not function properly. Decannulation can be attempted after the tube has been closed for three nights in acute cases. Much longer trial periods are necessary in the more chronic cases.

#### MEDICAL TREATMENT

Medical treatment is not separate from the operative treatment but the operative treatment is sometimes necessary before other treatment can be attempted. In conditions in which the lesion is not progressive and is likely to be of a temporary nature and when the danger of asphyxia is not too great, medical treatment without operative interference should be tried. The type lesions falling into this group would be acute infections, edemas due to allergies, glandular disturbances, nephritis and malnutrition. Moist oxygenated air is beneficial and provision should be made for such cases by hav-

ing equipment ready. Much of the success in the surgical and medical care depends on adequate preparation for them. Desiccated plasma, glucose, saline, gum acacia, lysate of casein, oxygen, suction equipment and humidifiers should be available when needed.

In acute infections the treatment is influenced by the bacterial findings. Antitoxin in diphtheritic infections and the sulfonamides or penicillin<sup>12</sup> in streptococcic, staphylococcic or pneumococcic infections will frequently give prompt improvement. The use of convalescent serum frequently obtainable from another member of the family who has recovered from a similar infection is recommended. The highest antibody titre is obtained about a week after the temperature is normal.<sup>13</sup>

Plasma protein concentration can be increased by giving plasma, amino acids, hydrolysate of casein, or transfusion. The concentration should be increased in all cases where plasma osmotic pressure is low. The normal should be about 7 per cent.

Baum<sup>14</sup> has reported good results in the treatment of acute laryngotracheobronchitis by the intravenous administration of hypertonic blood plasma.

Abbott<sup>15</sup> has used amino acids and hydrolysate of casein in the treatment of hypoproteinemia due to malnutrition. Hydrolysate of casein can be prepared rather cheaply and contains the essential amino acids. It might be used to increase plasma protein where frequent administrations are indicated. Gum acacia in concentrated 30 per cent solution has been used to increase the osmotic pressure of the plasma with success.<sup>16</sup>

The treatment of Ludwig's angina is early adequate incision and drainage of the submaxillary triangle with heat and supportive treatment.

The fluid intake should be adequate in all infections to prevent dehydration and aid in the elimination of toxins. Neo-arsphenamin and bismuth are indicated in syphilitic lesions although laryngeal lesions are more resistant to treatment than lesions located in other parts of the body. Allergies may be treated by small doses of adrenalin 1/1000 hypodermically, by nebulizer in 1/100 solution, by ephedrine combined with a nerve sedative by mouth and by desensitization.

Retropharyngeal and laryngeal abscesses should be opened guarding against insufflation by the position of the patient. Tumors should be removed if possible. The surgeon should be guided by the type, location and nature of the lesion.

Systemic diseases and conditions which cause edema should be treated from an etiological standpoint with a study of the plasma protein,

fluid balance and glandular function. Congenital webs are usually treated by passing a bronchoscope through them. A deformed epiglottis may be trimmed or removed if it is causing obstruction.

Nerve lesions—Laryngeal spasm will usually require no treatment but will pass off frequently before the physician can see the patient. Any contributing causes should be treated. Recurrent nerve paralysis if bilateral and causing obstruction requires tracheotomy. The causes should be sought and the lesion responsible for the condition treated. There is hope of improving the function by the use of the Kelly<sup>17</sup> or other operative methods if the cause can not be remedied.

#### 15 TRACHEOTOMIES

Analysis of the last 15 cases of tracheotomy at Mercy Hospital:

Infections—Acute laryngotracheobronchitis in 8. Six of these were under 3 years of age. There were three deaths. Diphtheria occurred twice and the ages were 5½ months and 1 year. Both recovered. The statistics show that obstructive symptoms occurred most frequently in children and that acute laryngotracheobronchitis was the most frequent cause.

Noninfections—Abductor paralysis occurred in three patients with ages 30, 48 and 50. Trauma was responsible for two. One, age 2, following the removal of a foreign body. One, age 3, following the drinking of hot tea.

This series shows that 10 of the last 15 tracheotomies were done to relieve the dyspnea due to infection, three for abductor paralysis and two following trauma.

#### A CASE REPORT

A 5-month old baby was admitted to Little Flower Hospital, April 5, 1942, with acute obstructive dyspnea which required immediate tracheotomy. There was a history of a cold with an increasing breathing difficulty over a four-day period. He had no membrane but there was much supraglottic and glottic swelling with fixation of the larynx. Cultures showed Klebs Loeffler bacilli, staphylococcus aureus, streptococcus and pneumococcus. Blood counts varied between 7,000 and 17,000 for white cells. Red counts 3,930,000 to 4,500,000. Urine was negative. Temperature varied between 102-104.

There were many rales, mucous plugs, periods of cyanosis and apnea with varying localized atelectases. He had 40,000 units of antitoxin, several courses of sulfathiazole therapy, high fluid intake, a room with as high a moisture content as possible, oxygen and suction therapy with constant nursing care. After four weeks the temperature was normal and after six weeks the tube was removed after three days' closure.

A second tracheotomy was necessary two days later because of dyspnea. The tube was removed one month later following plugging for one week and the patient discharged. A third tracheotomy was necessary six months later and

at this admission the larynx was studied under general anesthesia at St. Luke's Hospital, Cleveland. A paralysis of the left vocal cord was found. This was attributed to his diphtheria. He has had his tube closed off all Winter and his general condition is good. Decannulation is planned this Summer.

#### SUMMARY

1. It is essential to recognize obstructive dyspnea at once in order to treat it properly.
2. Etiological factors, symptoms and methods of differential diagnosis are presented.
3. The importance of preparation for the care of patients with stenosis is stated.
4. Recommendation is made that an artificial airway be established if there is danger of asphyxia regardless of etiology.
5. Antitoxin, sulfonamides, penicillin, plasma, convalescent serum, hydrolysate of casein, gum acacia, adrenalin, ephedrine neo-arsphenamin, moist oxygenated air and proper fluid intake are recommended in certain types of acute dyspnea. The indication for their use should be determined by the diagnosis and laboratory findings.
6. The last 15 tracheotomies are analyzed as to diagnosis and age incidence.
7. A case of laryngeal diphtheria with abductor paralysis and difficult decannulation is presented.

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# Clinical Use of Monomethyl Stilbesterol

RUTH H. ST. JOHN, M.D.

IN the six-year period following the commercial availability of diethyl stilbesterol, intensive effort has been directed toward the development of a synthetic compound which will combine the oral potency of the parent stilbesterol molecule and the freedom from side effect which is an attribute of the more costly natural estrogens.

The practising physician is confronted daily with the problem of the menopausal patient who can not tolerate the commonly used diethyl stilbesterol in doses sufficient to control her vasomotor disturbances, and who is financially unable to avail herself of the natural estrogens. All too frequently, the much needed substitution therapy is subsequently abandoned due to this economic factor, and the patient is forced to resign herself to her distressing symptoms and to rely on barbiturate sedation.

This situation creates a very real and practical interest in investigational developments concerning synthetic estrogenic substances, and the general practitioner is well advised to acquaint himself with the basic chemical differences in the various products now on the market. Trade names are still a source of confusion. Prescriptions written for "stilbesterol" generally mean diethyl stilbesterol and unless the physician is acquainted with the newer compounds by name, structure and potency, he will find it difficult to avail himself of the widening choice in synthetic estrogens when the occasion presents itself.

## HISTORICAL NOTES

Following the original work by Dodds and his associates in 1938,<sup>1</sup> diethyl stilbesterol has been the compound against which all related synthetic compounds have been clinically compared. Since the excellent summary of the literature by Morrell<sup>2</sup> in 1941, many other papers have attested to the physiological effectiveness of diethyl stilbesterol. The optimum dosage level of the oral preparation has been shown to be .5 mg. to 1.0 mg. daily as the dose most apt to control menopausal vasomotor disturbances without producing unpleasant side effects.

Early efforts to modify the stilbesterol molecule, using di-alkyl ethers, resulted generally in compounds of decreased potency and no lesser degree of untoward reactions when used clinically in effective doses.<sup>3</sup> Reid and Wilson<sup>4</sup> inves-

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tigated mono-alkyl ethers of stilbesterol with favorable results in regard to estrogenic potency and Geschickter and Byrnes<sup>5</sup> combined chemical and clinical assays to demonstrate the physiological effectiveness of mono-methyl stilbesterol.

A number of papers have been published describing the clinical effects of mono-methyl stilbesterol, and there are, of course, varying opinions of its value. Abarbanel<sup>6</sup> finds the compound no less upsetting to the gastrointestinal tract than diethyl stilbesterol when used in equivalent oral doses, and he states also that in his series of cases diethyl stilbesterol is five times as potent as the monomethyl ether. Elden<sup>7</sup> reported a series of 36 cases in which monomethyl stilbesterol gave favorable results in a high percent of cases, with 1 mg. daily of the oral preparation proving to be the average effective dose. Buxton and Sullivan<sup>8</sup> reported 25 cases in which the estrogenic potency of monomethyl stilbesterol was demonstrated with only a small incidence of side effects.

## ORIGINAL DATA

The present report is prepared in the continued attempt to determine whether or not the monomethyl ether of stilbesterol may answer the need for a potent, inexpensive synthetic estrogen with relative freedom from side effects. The study was begun at the Wisconsin General Hospital, under the direction of Dr. Elmer L. Sevringhaus. Eighteen cases were seen there in the out-patient department. The remainder of the cases used in this series are from the private practise of the author. Monomethyl stilbesterol has been used in 26 additional cases, but the records of these patients are inconclusive due either to the short period of therapy, or the nature of the cases.

Of the 41 cases, 21 were treated for a natural menopause, 12 for surgical menopause, and eight for hirsutism associated with amenorrhea or menstrual irregularity. In all cases, oral medi-

We are indebted to Dr. L. Reiner of the Wallace and Tiernan Products, Inc., Belleville, N.J., for a generous supply of "Monmestrol".

Submitted July, 1944.

| (Case)                  | Oral<br>Dose of<br>Monomethyl<br>Stilbesterol | Relief<br>Obtained | Side<br>Effects        | Comparison<br>With Other<br>Estrogens    | REMARKS                                                   |
|-------------------------|-----------------------------------------------|--------------------|------------------------|------------------------------------------|-----------------------------------------------------------|
| Natural<br>menopause 1  | 1 mg. daily                                   | excellent          | none                   | as good as<br>natural estrogen           |                                                           |
| 2                       | 1 mg. daily                                   | excellent          | none                   | none used                                |                                                           |
| 3                       | 1 mg. daily                                   | good               | none                   | as good as<br>natural estrogen           |                                                           |
| 4                       | 1 mg. daily                                   | excellent          | none                   | none used                                |                                                           |
| 5                       | 1 mg. daily                                   | excellent          | none                   | none used                                |                                                           |
| 6                       | 0.5 mg. daily                                 | excellent          | none                   | as good as<br>natural estrogen           |                                                           |
| 7                       | 0.5 mg. daily                                 | good               | none                   | as good as<br>natural estrogen           | pelvic congestion on 1 mg.<br>occas. hot flash on 0.5 mg. |
| 8                       | 1 mg. daily                                   | excellent          | none                   | as good as<br>natural estrogen           |                                                           |
| 9                       | 1 to 2 mg. daily                              | poor               | none                   | no relief on<br>any type                 | persistent vasomotor<br>reactions                         |
| 10                      | 1 mg. daily                                   | excellent          | none                   | better than<br>20,000 u estrone          |                                                           |
| 11                      | 1 mg. daily                                   | excellent          | none                   | better than 2 mg.<br>diethyl stilbestrol | complained of weakness<br>on diethyl stilbesterol         |
| 12                      | 1 mg. daily                                   | good               | slight<br>nausea       | better than 1 mg.<br>stilbesterol        | smaller dose ineffective                                  |
| 13                      | 0.5 mg. daily                                 | fair               | nausea<br>after 6 wks. | as good as<br>diethyl stilbestrol        |                                                           |
| 14                      | 1 mg. daily                                   | good               | none                   | better than 1 mg.<br>diethyl stilb.      |                                                           |
| 15                      | 0.5 to 1 mg. daily                            | poor               | nausea<br>dizziness    | relief on<br>natural estrogen            |                                                           |
| 16                      | 1-2 mg. daily                                 | poor               | nausea<br>headache     | relief from .5 mg.<br>diethyl stilb.     |                                                           |
| 17                      | 1 mg. daily                                   | excellent          | none                   | as good as 1 mg.<br>diethyl stilb.       |                                                           |
| 18                      | 0.5 to 1 mg. daily                            | fair               | headache               | as good as<br>diethyl stilb.             | no vasomotor relief on<br>any synthetic estrogen          |
| 19                      | 1 mg. daily                                   | fair               | none                   | natural estrogen<br>better               | no feeling of "well-being"<br>on synthetics               |
| 20                      | 1 mg.<br>cyclic R therapy                     | good               | none                   | none used                                | cycle prolonged 10 days                                   |
| 21                      | 1 mg.<br>3 x week                             | excellent          | none                   | none used                                | vaginal pruritis only<br>complaint (controlled)           |
| surgical<br>menopause 1 | 0.5 to 1 mg. daily                            | excellent          | none                   | none used                                | symptoms vary with do-<br>mestic troubles                 |
| 2                       | 1 mg. daily                                   | excellent          | none                   | none used                                |                                                           |
| 3                       | 1 mg. daily                                   | good               | none                   | as good as<br>natural estrogen           |                                                           |
| 4                       | 1-2 mg. daily                                 | poor               | nausea<br>flatulence   | natural estrogen<br>better               | 1 mg. did not control<br>vasomotor symptoms               |
| 5                       | 0.5 to 1 mg. daily                            | fair               | headache               | diethyl stilbesterol<br>better           | 0.5 mg. did not control<br>symptoms                       |
| 6                       | 1 mg. daily                                   | excellent          | none                   | better than 1 mg.<br>diethyl stilb.      |                                                           |
| 7                       | 1 mg. daily                                   | excellent          | none                   | better than 1 mg.<br>diethyl stilb.      |                                                           |
| 8                       | 1 mg. daily                                   | excellent          | none                   | better than 1 mg.<br>diethyl stilb.      |                                                           |
| 9                       | 0.5 to 1 mg. daily                            | fair               | slight<br>nausea       | as good as<br>1 mg. diethyl stilb.       |                                                           |
| 10                      | 1 mg. daily                                   | good               | none                   | None used                                | no feeling of well-being                                  |
| 11                      | 1 mg. daily                                   | excellent          | none                   | as good as<br>natural est. or diethyl    |                                                           |
| 12                      | 1 mg.                                         | poor               | nausea                 | natural estrogen<br>no better            |                                                           |

## Hirsutism associated with menstrual irregularities

|   |                           |           |      |  |                                                          |
|---|---------------------------|-----------|------|--|----------------------------------------------------------|
| 1 | 1 mg.<br>cyclic R therapy | good      | none |  | hirsutism unchanged<br>irreg. cycles more<br>normal      |
| 2 | "                         | poor      | "    |  | excessive bleeding                                       |
| 3 | "                         | fair      | "    |  | acne improved—hirsutism<br>unchanged—cycles<br>prolonged |
| 4 | "                         | excellent | "    |  | menstruation initiated<br>after 14 mo. amen-<br>orrhea   |
| 5 | "                         | good      | "    |  | menstruation initiated<br>after 5 mo. amen-<br>orrhea    |
| 6 | "                         | good      | "    |  | oligomenorrhea improved                                  |
| 7 | "                         | poor      | "    |  | amenorrhea persisted<br>after 3 mo.                      |
| 8 | "                         | good      | "    |  | menst. irreg. improved—<br>hirsutism unchanged           |



cation was employed in doses ranging from .5 mg. to 2 mg. daily, and the minimum length of treatment was three months.

In the group of patients classified as having menopausal symptoms, improvement was gauged by control of hot flashes, sleeplessness, depression, muscular weakness, and paresthesias of the extremities; and, objectively, by improvement in vaginal smears.<sup>9</sup> One case complained only of vaginal pruritis. Eight cases had been treated with no estrogen therapy other than monomethyl stilbesterol. In 13 cases, diethyl stilbesterol had also been used and in 14 cases, a natural estrogen had been employed for comparison.

Of these 33 cases, 23 reported good or excellent relief on menopausal symptoms on oral dosage averaging 1 mg. daily; 6 were unable to tolerate 1 mg. due to nausea and headache, and in this group, .5 mg. was not sufficient to control the vasomotor disturbances. One case had persistent vasomotor disturbances which had resisted all types of estrogen therapy, although she experienced no gastrointestinal distress on 2 mg. daily of monomethyl stilbesterol, and one case obtained relief from hot flashes while on monomethyl stilbesterol, but failed to obtain the increased energy and sense of well being which she had had with natural estrogen therapy.

Of the 13 cases in which it was possible to compare the effect of monomethyl stilbesterol and diethyl stilbesterol, 7 cases reported better results with monomethyl than with diethyl stilbesterol at the same dosage level. Four patients were controlled as well with one drug as with the other, and 2 patients experienced better results with diethyl stilbesterol.

In the group of patients with hirsutism, menstrual irregularities, and acne, monomethyl stilbesterol was used in cyclic therapy using 1 mg. depending upon the nature of the cases, and in no instance was nausea or other untoward effect observed in the series of 8 patients. All of these patients had been given the drug from 3 to 5 months.

#### CONCLUSIONS

Monomethyl stilbesterol has been used in a series of 41 cases, using oral therapy in doses varying from 0.5 mg. to 2.0 mg. Thirty-three cases presented menopause symptoms and 8 cases were under therapy because of hirsutism and associated menstrual irregularities. Of the total series, 68 per cent of the cases showed good or excellent response to therapy, with monomethyl stilbesterol, and 21 per cent showed side effects of nausea, headache or dizziness. In the 14 cases where comparative results could be observed with the use of diethyl stilbesterol and monomethyl stilbesterol in the same patient, 7 cases showed better response to monomethyl stilbesterol than to diethyl stilbesterol in equal dosage which would indicate that in some in-

stances, monomethyl stilbesterol would answer the need for a potent synthetic estrogen which is relatively free from side effects.

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#### Tuberculosis Control in Hospitals

Few hospitals will accept tuberculosis of the lung as a disease to be treated within their walls except the large public institutions with special facilities for that purpose. Recently private hospitals in Chicago were asked:

1. Do you admit patients with pulmonary tuberculosis to your hospital for treatment of that disease?

2. Do you admit patients with known pulmonary tuberculosis to your hospital for treatment of other conditions?

Of the 73 hospitals which replied, 5 answered question one with "Yes"; 68 with "No"; 25 replied to question two with "Yes" and 48 with "No" or with comments which amounted to a negative reply. The answers indicated that hospital administrators do not consider the admission of the tuberculous an asset to hospital service. In fact many of them thought this was an attempt to uncover an administrative deficiency.

In a community with sufficient beds available in tuberculosis hospitals this attitude does not hamper phthisiotherapy, although in the past physicians have been deprived of facilities to hospitalize their patients in this manner. With the increase of surgical treatment this has often proved hampering. In communities with inadequate facilities for the treatment of tuberculosis failure to exploit all the available space, especially when numbers of general hospital beds were vacant, has seemed unjustified.—*Tuberculosis Control in Hospitals*, Robert G. Block, M.D., NTA Bulletin, Aug., 1944.

\* \* \*

Over the centuries tuberculosis has killed more people than has war. In 1943, tuberculosis killed approximately 56,000 people in the United States. That is the equivalent of four army divisions—four divisions who will not march in this war either on the home front or abroad. This is the toll exacted by our complacency towards an enemy we know how to conquer.—"Tuberculosis in a World at War" (NTA).



# Adenocarcinoma of the Head of the Pancreas

ROBERT T. THOMPSON, M.D., and GEORGE Y. ABE, M.D.\*

**Case 186537:** A negro male, age 53 years, was admitted to the medical service of Cincinnati General Hospital on August 31, 1943, with complaints of weakness, poor appetite, itching and "yellow eyes" during the past three months.

**Past History:** The patient had no hospital record and had never been seriously ill before. He had whooping cough, age 9 years, and gonorrhea, age 27 years. He had had occasional sore throats. There was no history of chancre or of antiluetic treatment. He had been twice happily married. The first wife bore two children and was healthy until 8 years after marriage when she was killed in an automobile accident. The second wife is living and well but has borne no children. The patient had passed repeated physical examinations given by his employer and followed the heavy labor of shoveling sand into a sand-blasting machine.

**Present Illness:** Three months ago the patient noticed the onset of weakness which developed insidiously and forced him to quit work about two months ago. With the onset of weakness he noticed that his "appetite got poor". He developed an aversion to fatty and greasy foods. He "had much gas" and belched frequently and found that he could obtain relief for a while by taking soda bicarbonate. With this complaint he had epigastric discomfort which he defined as indigestion, but he denied abdominal pain. He vomited only on two occasions, each about one hour after eating and the vomitus was of a pale color, neither brown nor green. Concomitantly with these complaints his urine became progressively darker, then black, and the stool became grey. His eyes became yellow and itching was severe early in the illness but later abated somewhat. There has been no diarrhea or malena. His bowels moved as before, once or twice daily. At the onset of this illness three months ago, he weighed 158 pounds and on admission, he weighed 138 pounds.

No family history was obtainable and there had been no known exposure to tuberculosis. Diet had been adequate in variety and amount of food taken until the onset of the present illness.

**Physical Examination:** Temperature 101°F; pulse 108; respiration 30; blood pressure 126/78. The patient was a muscularly developed and fairly well nourished middle aged negro male who was comfortable in bed. He appeared somnolent but was mentally clear and cooperative. The skin showed many scratch marks and small sores over the entire body. There was no lymphadenopathy. The conjunctivae and sclerae were deeply yellow. The mucosa of the palate and the under surface of the tongue showed a yellow tinge. The tonsils were small and the trachea was in the midline. The chest was symmetrical and the lung fields were clear,

but the respiratory excursion was slightly decreased. There was no venous distention, no cardiac enlargement, and no cardiac murmur. The abdomen was flat, non-tender and not rigid. The liver was palpable. Its border was felt fairly distinctly at the level of the umbilicus in the right midclavicular line. It was also enlarged to the left but the right lobe seemed preponderantly enlarged. There were no other masses or organs palpable. Rectal examination was negative. Neurological examination was normal. There was no edema of the extremities.

**Laboratory Data:** Sept. 1, 1943: Hemoglobin 10 grams, Red blood cells 3,700,000, White blood cells 31,500, Neutrophils 87 per cent, Lymphocytes 11 per cent, Monocytes 1 per cent, Eosinophiles 1 per cent. Sept. 16: Hemoglobin 10 grams, White blood cells 64,850, Neutrophils 94 per cent, Lymphocytes 5 per cent, and Monocytes 1 per cent. Urinalyses were essentially negative except for traces of albumin, bile 4 plus, and no urobilinogen on seventeen examinations. Stools were formed, cream color to grayish, and contained many fat globules. Stools were negative for bile and urobilinogen. Stools were guaiac negative until four days before death when they became dark brown by gross and microscopic blood.

Serology was negative. Electrocardiogram was within normal limits. Blood urea nitrogen increased from 18 to 67 milligrams. Sulfadiazine level reached 8.9 milligrams. Blood cholesterol level was 228 milligrams. Serum phosphatase was 12.1 Bodansky Units. Galactose tolerance was poor (7.4 grams excreted). Prothrombin time was prolonged. Icteric index increased from 93 to 150.

Gastric analysis showed 5° free acid and 5° total acid with practically no response to hypodermic injection of Histamine grain 1/76. Duodenal drainage was not successful but analysis of fluid from Wangenstein suction three days before death showed the fluid to be dark brown and thin, to have fat globules and undigested food, microscopic blood and no bile. X-ray showed spasm and irritability in the first portion of the duodenum, and puddling of the barium in the duodenal loop and jejunum. X-ray also showed atelectasis of lung—right lower lobe.

**Course:** Temperature showed a septic course with daily rises over 102°F the second week, and subsided to a subnormal range the last week of life. Pulse followed temperature. Respirations averaged 26 per minute but became rapid two days before death.

Jaundice became progressively deeper and stools were persistently acholic. The urine was always heavily stained with bile and negative for urobilinogen. The stools always contained fat globules. They became guaiac-positive four days before death and were grossly bloody three days before death. The stomach contents, by Wangenstein suction three days before death, were guaiac positive and contained microscopic blood, but the bile test was negative.

Three days after admission the patient devel-

\*The authors represent respectively the Medical and Pathological Services of the Cincinnati General Hospital. This is the twentieth in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.



oped rales at the bases of both lung fields, more on the right. Two blood cultures taken the next day were positive for hemolytic staphylococcus aureus. Blood culture remained positive until death. Ascites began about the fourth hospital day and progressed gradually. Generalized edema appeared about the 12th hospital day and increased markedly shortly before death.

Sulfadiazine was given six grams daily from the seventh to the 13th hospital days without any beneficial effect. Whole blood transfusions were given in an effort to combat progressive anemia and falling serum proteins, but without avail. Abdominal distention appeared on the 15th hospital day and progressed until death. In spite of Wangenstein suction, delirium appeared on the 16th hospital day. Ileus developed terminally so that the patient died of anemia, cachexia and ileus.

The clinical diagnoses at death were: Carcinoma of ampulla of Vater with complete obstruction; multiple liver abscesses due to ascending infection due to hemolytic staphylococcus with septicemia and peritonitis; atelectasis of lung, right lower lobe; bilateral broncho-pneumonia.

**Necropsy (N-43-382) Gross Examination:** External examination revealed the presence of marked icterus, especially noticeable in the sclerae and conjunctivae. Edema of the lower legs was also present.

On opening the body the serous linings of the great cavities were found to be markedly yellow. The right pleural cavity contained 800, the left 700, and the abdominal cavity, 500 cc. of clear, yellow, serous fluid. The somewhat thickened pericardial sac was lined by a rough "bread and butter" serous membrane and contained 30 cc. of slightly cloudy, yellow fluid.

Weighing 2650 gms., the anterior edge of the enlarged liver was found 10 cms. below the edge of the right costal margin in the mid-clavicular line. From underneath the anterior edge projected the greatly distended, thin-walled gall bladder. Sections of the liver showed in addition to "nutmegging", increased friability, brownish-tan tissue and the presence of scattered miliary grayish-white abscesses containing thick, creamy fluid. All of the extrahepatic ducts were dilated. The common bile duct measured 60 mm. in circumference. It was found to end blindly in a hard, grayish-white, irregular, invasive mass, which measured roughly 2 cms. in diameter and was located in the head of the pancreas in the region of the ampulla of Vater and beneath the mucosa of the duodenum.

The pancreas was normally situated. On section, the duct of Wirsung was found greatly dilated and it also ended in the tumor mass. The pancreatic tissue surrounding it was very thin. Small lobulations were widely separated by fibrous tissue. The duct of Santorini was not found.

Approximately equal in size, the kidneys weighed 675 gms. together. The capsules stripped with ease revealing a smooth tan surface with scattered yellow specks. Coronal sections showed a wide cortex with scattered yellow specks and the reddish-green pyramids containing isolated and confluent yellow abscesses. The vessels were quite congested. Only slight hyperemia of the mucosa of the pelvis was noted.

The heart weighed 425 gms. Fibrinous exudate covered the epicardium. Other than a hypertrophied and dilated heart, no further abnormalities were seen.

The lungs weighed 485 and 535 gms. right and left respectively. The right and left lower lobes were red, moist, subcrepitant, and contained small patchy consolidated areas. The upper lobes were somewhat red, a little subcrepitant, but rubbery. These changes were more marked in the left lung than in the right.

The large spleen weighed 310 gms. Sections revealed a red, firm, splenic tissue. The mucosa of the gastro-enteric tract was hyperemic. Examination of the brain, adrenals, urinary bladder, prostrate, ureters, aorta, and coronary arteries revealed only minor deviations from the normal.

**Microscopic Examination:** The mass in the head of the pancreas consisted of duct-like arrangements of epithelial cells in a stroma of fairly dense and abundant fibrous connective tissue. The ampulla of Vater could not be found. The growth also invaded the muscularis and submucosa of the duodenum.

The acinar glands in the head of the pancreas showed atrophy and the intact islets of Langerhans were found compressed together into groups, thus appearing to be more numerous than normally found in this region. Sections from the body and tail revealed isolated and scattered groups of acinar glands undergoing compression atrophy. Diffuse fibrosis and lymphocytic reaction replaced the acinar glands and dominated the picture. The islets of Langerhans, although few in number and present in groups, appeared capable of function.

Typical abscesses were present in the liver. Every portal area contained infiltration of polymorphonuclear leucocytes. The hepatic cells revealed toxic changes and moderate atrophy. Bile retention was evident in the sinusoids.

The kidneys also showed abscesses, in the cortex and pyramids. Bile was present in the tubules.

The epicardium was thickened and lined by a fibrinous exudate. The myocardial fibers were somewhat pale, granular, and the cross-striations were indistinct, denoting toxic changes.

In the lung focal groups of alveoli contained sero-fibrino-purulent exudate and the walls were thickened by congestion.

No other pertinent pathological change was noted except mild to moderate evidences of passive congestion in the liver, lung, spleen, and intestine.

**The final pathological diagnoses were:** Adenocarcinoma, ductile type, primary in the head of the pancreas; obstruction of the duct of Wirsung; atrophy and fibrosis of the pancreas; obstruction of the ampulla of Vater; acute suppurative cholangitis; acute suppurative nephritis; acute fibrinous peri- and epicarditis; terminal lobular pneumonia; cardiac dilatation and myocardial hypertrophy; passive visceral congestion.

#### DISCUSSION

This case presents the problem of diagnosis of a lesion obstructing the bile and pancreatic ducts at the ampulla of Vater. Early diagnosis is difficult. An intolerance for fatty foods and an abnormal amount and quantity of fat in the stools may be the earliest indications of pancreatic duct obstruction. Jaundice with or without pain in any patient over fifty years of age may be the earliest indication of biliary duct



obstruction. Dr. Leon Schiff recommends observation of the patient for a period of six or seven weeks after the onset of jaundice. This is particularly applicable to cases in the younger age group in which the diagnosis is doubtful. In this period of time the course of the disease will help to indicate whether hepatitis or carcinoma is the cause. Spasticity of the duodenum seen by X-ray may aid in the diagnosis. The gall bladder may or may not be palpable, but the liver is usually enlarged. Even if the jaundice is remittent the diagnosis of carcinoma must be strongly considered, and if the obstruction of the bile ducts is complete as indicated by stool and urine tests, the diagnosis is almost conclusive.

Banting, Best and Macleod in their isolation of insulin from the islet tissue of the pancreas in dogs, found that "the acinous, but not the insular cells become degenerated in seven to ten weeks after ligation of the ducts". The pathological findings in this patient show an analogous advanced degeneration of the acinar tissue of the pancreas. The time element of this patient's three-month clinical history corresponds closely to Banting, Best and Macleod's ten-week period for complete degeneration of acinar tissue following ligation of the pancreatic duct in dogs.

Any delay in abdominal exploration beyond seven weeks adds many hazards to an already difficult surgical procedure. There is the degeneration of acinar cells of the pancreas mentioned above. There is also the danger of infection in the biliary tract secondary to obstruction. In this case it led to multiple liver abscesses, septicemia and kidney abscesses. With the impaired liver function resulting from these complications any surgical procedure becomes less feasible as their severity increases. Early diagnosis and early exploration offer the best hope of surgical excision of a tumor at the ampulla of Vater.

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#### Celiac Disease

The significant roentgenographic changes in coeliac disease are generalized osteoporosis, marked thinning of the cortex with softening, bowing and fractures of the long bones, and kyphosis. Of particular interest are the transverse osteoid zones described by Looser which simulate pathological fractures. They usually occur in cases in which the disease is well advanced and they have a tendency to be symmetrically distributed. Transverse striations in the ends of the diaphyses of the long bones are often found.—Ralph S. Bromer, M.D., Bryn Mawr, Pa.; *Minnesota Medicine*, Vol. 27, No. 11, Nov., 1944.

#### Chronic Brucellosis, a Public Health Problem

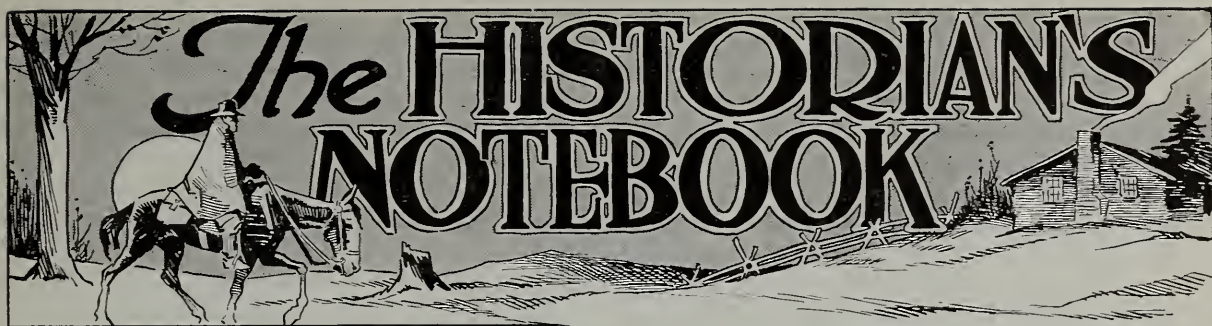
Inasmuch as brucellosis is not only contracted from infected cows but also from infected swine and goats, it was decided to go to some of the packing houses and talk to some of the veterinarians. Since practically no goats are raised in this part of the country, brucellosis in goats does not present a problem. However, the processing of hogs plays an important role in the dissemination of brucellosis.

It is the writer's opinion that brucellosis in man can be reduced if not eradicated. It is only natural that any steps taken to eradicate brucellosis in animals will inevitably lead to the eradication of brucellosis in man. Our recommendations, therefore, are based upon the eradication of brucellosis in animals. For this purpose several prominent veterinarians were consulted and their opinions as well as those of the writer are set forth herewith:

1. All cattle, swine and goats should be tested for Bang's disease. State laws should be enacted requiring testing. Such laws are in existence for tuberculosis and they could easily be amended to include Bang's disease.
2. All reactors found should be branded on the jaw with a capital "B" and provisions made for the sale of such animals to the packing houses who have government inspectors.
3. Legislation should be enacted making it unlawful for any butcher to buy animals so branded for slaughter.
4. Provision should be made for the reimbursement of the farmer so that he may not sustain financial loss when he sells the reactors.
5. Calfhood vaccinations with *Brucella abortus* antigen should be compulsory.
6. Meatcutters and packing house personnel should receive education and instructions as to the proper handling of branded animals.
7. The United States Public Health Service Standard Milk Ordinance should be adopted and enforced.

We believe that if these steps were carried out they would lead to a reduction in, and eventually to the eradication of Bang's disease in animals as well as man. If no infected cattle can come into the hands of retail butchers, the spread of the disease from homekilled summersausage would be eliminated. Milk ordinances will help to prevent the spread of the disease through dairy products and the branding of cattle would caution any meat handler in packing houses to work with gloves in order to prevent infection.—Eric Lehr, P.A. Surgeon (R) U.S.P.H.S., East St. Louis; *The Illinois Med. Jr.*, Vol. 86, No. 5, Nov., 1944.





*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## Medical Curiosities

RALPH M. WATKINS, M.D.

DECEMBER 2. To hand comes an interesting old reprint. It illustrates the plan of thought and the groping about in the dark which our predecessors experienced. In this day it seems to us that the answer to the problem of diphtheria is completely ours, but such was not the case in 1875, when the study was made which comprises the subject of this reprint. This thought may help to make us a little humble when we realize that today in the stead of our ancestors 70 years ago, we ourselves are fumbling about trying to solve the questions of certain other diseases. It may well be that 70 years hence our descendants may look back on our present theorizing with a smile.

The reprint in question is called "Clinical Study of Diphtheria, by George Bayles, M.D., of New York, Treatment with Elixir Iodo-Bromide of Calcium Compound and Bromo-Chloralum". It was published by Tilden and Co. in 1877 and is based upon Dr. Bayles' experience with a "score of the most unmistakable cases of diphtheria in 1875".

There are many expressions through the reprint which I should like to use in toto at intervals through this review. First of all Dr. Bayles was quite sure that he had a new method of treatment at hand. He reports the number of cases, the seasons of occurrence, the ages and then begins to explain how he made sure of the diagnosis. How was he going to be sure that he was dealing with diphtheria and not with "croupous or membranous laryngitis"? He found a test by which he discovered that diphtheria was "primarily constitutional". The proof: "when, in each case, I could make a slight abrasion or scarification of the cutaneous surface on some part of the person quite remote from the usual seat of visible local lesion, and soon observe the formation of a characteristic membranous or tissual patch, a fibro-plastic slough, covering the surface of the wound, I had something very positive to aid in my diagnosis". He apparently test-

### *The Author*

● Dr. Watkins, Cleveland, Ohio, is a graduate of Syracuse University College of Medicine, 1920; F.A.C.P.; diplomate, American Board of Internal Medicine; and chief of Medical Service, The Woman's Hospital, Cleveland.

ed each one of the patients by this means and as he says he often found a definite response to his test before any involvement of the fauces and, at times, when no nose or throat lesion appeared at all. Thus it would seem that if the scarred area became infected he considered the case to be one of diphtheria. He waited 10 hours after making the abrasion and in that time the evidence was expected to appear. Even if there was no sign of disturbance in the throat he proceeded to treat the case by his special method.

He watched also for other signs. If he found "quick, irritable pulse . . . internal temperature as registered by the clinical thermometer, that clearly indicates fever . . . a marked etiolation of complexion . . . a pale or washed out appearance of the iris . . . the stomach rejecting perhaps the blandest thing that can be swallowed . . . diarrhea apparently due to utter languor of the intestinal canal . . . a pettish temper", he was more than ready to pronounce the case one of diphtheria.

Then he mentions again his scarification test, compares it to remote pustules after vaccination against smallpox and feels that it tends helpfully toward "settling the question of the individuality of diphtheria as regards its relation to any form of croup".

Now he describes his cases, 20 children, and divides them according to nationality. Ten are Irish, seven American, two German and one English. He describes the symptoms in summary, notes the presence of albumin in the urine, the

pseudo-membrane on the excoriated surface, the duration, and then starts to talk of his idea of the causes. He would have made a good sanitary officer for his time. He notes that there was no prevalence of "zýmotic nor malarial diseases", but goes on to report facts relating to the environment of the patients.

He records the amount of air space belonging to the patient, the "quality of the meat" and "everything of sanitary importance from the roof to the cellar, from the street to the remotest corner of the lot, above the soil, below the soil, temperature, humidity, influences meteoratious and influences teluric" and stresses the dense population of the district, describes the houses whether mammoth tenements or low hut-like shanties and alludes to the "frequent puerperal confinements and oft-recurring catamenial impurities, the ignorance and disdain of the simple principles of dirt, ventilation and cleanliness" of the women, the "foul emanations and exhalations" and concludes that there was present a "laboratory of noxious agencies that must exert a potent power for evil".

"Notwithstanding all that, I claim that there were no specific germ-influences at work", but rather incorrect living, unsavory people, untidy apartments, clothing and animals.

Therefore, Dr. Bayles believes that diphtheria is an "autochthonous disease" and he says that he is even prepared to accept the doctrine that it is "homo-autochthonous".

Dr. Bayles then compares the results of his treatment with that of a Dr. C. E. Billington who reported at about that time 124 cases of diphtheria with 90 recoveries. Dr. Bayles' series consisted of only 20 cases diagnosed according to his method but, since he had no deaths, he felt that percentage-wise he was ahead of Dr. Billington. He compares Dr. Billington's treatment with his own and points out the ways in which they differed. First, he antagonized or eliminated the causes whereas Dr. Billington destroyed the contagion. Second, Dr. Billington subdued the inflammation by removing the cause but Dr. Bayles, by anticipating the disease by means of his test, removed the cause and the inflammation did not appear or appeared only to disappear by "spontaneous decadence". Third, Dr. Billington says "combat the absorption . . . at which the local disease has manifested". Dr. Bayles says "purge the poisonous element from the physical economy".

"Having such a means at my disposal . . . I was not at a loss how to act." In his statement he referred to his test and planned his treatment as follows: "My first intention was by a vigorous blow which should resound throughout the whole system, metaphorically speaking, to abort the disease." He made use of calomel in "one courageous dose", never less than 10 grains

nor more than 30. Then he gave Dover's powder every hour until he had secured ample diaphoresis and then used a "depurative" medicine, the "elixir iodo-bromide calcium compound" which had "tonic resolvent, diuretic and aperient properties". The foods allowed consisted of milk, then "wine-whey, sillabub, ice cream" and invariably iced champagne. As often as thrice in 24 hours he bathed the patient with a tepid lotion of water and salicylic acid.

Regarding the germ theory of the cause of diphtheria he says "two years ago I entertained without misgiving a belief in the intensely contagious and actively portable nature of the diphtheric poison, and strongly advocated the peremptory isolation of all cases by legislative enactment, so that it might be stamped out. I am not disposed to be a supporter of such radical ideas any longer."

He goes to some trouble to explain the action of the wonder-working medicine, states that it contains bromine, iodine, chlorine, calcium, magnesium, iron, sodium and potassium. They are probably loosely combined even as are the minerals of the mineral spring waters, but this does not impair their efficiency. They have alterative and stimulative actions, supply nutrient elements to the blood and act as a "tonic to the lagging secernent system".

\* \* \*

This then is Dr. Bayles' contribution to the treatment of diphtheria in 1875. The doctor presented his paper before the New York State Medical Society soon after it was completed and had the ill fortune to encounter one of the powers of the Society in the person of the learned Dr. E. R. Squibb, the well-known manufacturing chemist. At the end of the above dissertation is a letter to the editor of the *Virginia Medical Monthly*, in which this paper originally appeared, signed by Dr. Bayles and complaining of the treatment which he received at the hands of Dr. Squibb.

It seems that Dr. Bayles was allowed to read his paper, which contained a new sort of radicalism in therapy, before the Society but at the instigation of Dr. Squibb general discussion of the paper was postponed to a later date. When the discussion was finally held, Dr. Bayles was not present because the poor man had not been notified. It was apparent that the Society deemed him guilty of using a proprietary nostrum but Dr. Bayles maintains that the iodo-bromide calcium compound was no more proprietary than many of the prominent Dr. Squibb's preparations.

The kernel of the whole matter is revealed on the last page of the reprint where there is handsomely offered to the medical profession the famous combination of iodine, bromine, chlorine, etc. etc., as the New Remedy in Diphtheria, namely Diphtherine, made by Tilden and Co.



# Conditions Under Which Private Physician and Civilian Hospital Will Be Paid for Care of Disabled Veteran

**W**HAT are the regulations of the Veterans Administration pertaining to the treatment of veterans by physicians in private practice and to the hospitalization of veterans in private institutions, as well as city, county or state hospitals?

Under what conditions will the physician in private practice and the civilian hospital be reimbursed for services rendered?

With which officials of the Veterans Administration should the physician in private practice and the civilian hospital superintendent deal on such matters?

These, and similar, pertinent questions are being raised by Ohio physicians and hospital officials as an increasing number of discharged service men return home, many of whom are eligible for the services and benefits provided by the Veterans Administration.

## BASED ON OFFICIAL ADVICE

This article attempts to answer some of these questions. It is based on information supplied by the chief medical officer, Veterans Administration, Dayton, Ohio, in answer to a request filed with the Veterans Administration by the Executive Secretary of the Ohio State Medical Association.

Appended are Veterans Administration regulations pertaining to the utilization of facilities other than those under the direct and exclusive jurisdiction of the Veterans Administration which are of special interest to physicians in private practice and civilian hospitals.

Some of the main points covered by the regulations and other information of importance follow:

1. Medical care and attention, whether by private physician or civilian hospital, must have prior authorization of the Veterans Administration before reimbursement may be made, except in connection with the treatment of a medical emergency arising from a disease or injury which has been adjudicated as service incurred.

2. If a private physician or superintendent of a civilian hospital encounters such a case, he should get in touch with the Chief, Reception and Out-Patient Service, of the Veterans Administration Facility nearest the home of the veteran, within 24 hours of the first contact with the patient, in order that proper authorization for treatment or hospitalization, or both, may be made.

## ALL CONDITIONS MUST BE MET

3. In cases where prior authorization for medical and hospital services is not obtained, reimbursement for the payment of the medical and

hospital services may be presented to the Veterans Administration Central Office through the Regional Office or Facility in whose territory the treatment was rendered, providing all of the following conditions are met:

(a) The treatment was rendered for a service-connected condition only, or for the relief of an associated nonservice-connected condition, which in the determination of the medical director was aggravating the disability of basic service-connected disorder;

(b) The treatment was rendered in a medical emergency;

(c) Government facilities were not feasibly available and travel would have been hazardous.

4. Under existing conditions, neither outpatient treatment nor hospitalization in a civilian hospital may be authorized for treatment of non-service-connected conditions, except in the event that the condition is aggravating a service-connected disability.

## EXAMINERS DESIGNATED

5. In the majority of Ohio communities the Veterans Administration has designated medical examiners to whom service-connected veterans are referred for treatment and to whom they are directed to apply in event of emergency.

6. Certain hospitals have contracts with the Veterans Administration for the care of service-connected cases when proper authorization has been made.

7. Veterans in training for Vocational Rehabilitation authorized by the Veterans Administration are entitled to treatment or hospitalization, if indicated, for any condition which interferes with the continuation of vocational training, as well as for treatment of service-connected disabilities. However, veterans given training under the G.I. Bill of Rights are entitled to treatment only for service-connected disabilities.

## WOMEN VETERANS

8. Women war veterans, needing treatment in a medical emergency for a condition either service-connected or not service-connected, may be authorized admission to a private hospital not under contract, if a government or private contract facility is not feasibly available, without procurement of prior approval of the medical director. In such cases, the provisions referred to in paragraphs 1, 2 and 3, above, will apply. Care for pregnancy and childbirth is not authorized.

9. Some veterans seeking a pension believe that a statement from their private physician, based on their history alone and not upon the physical findings, will help them obtain hospitali-



zation and subsequently, a pension. This is a misunderstanding. A veteran who has no service-connected disability may not be hospitalized upon his request, or on the recommendation of his private physician, for the purpose of securing examination and observation, since this type of hospitalization is made only upon the authority of the Adjudicating Service of the Regional Office of the Veterans Administration having jurisdiction, or upon the authority of the service in the central office having jurisdiction.

10. There are three Veterans Administration Facilities in Ohio to whom inquiries may be transmitted by physicians and hospitals. They are located at Brecksville, Chillicothe and Dayton.

#### REGULATIONS WHICH APPLY

Regulations covering the utilization of facilities other than those under direct and exclusive jurisdiction of the Veterans Administration, follow:

(A) Hospitalization will not be authorized in Government facilities other than those over which the Veterans Administration has direct and exclusive jurisdiction until agreement covering such service has been approved. Such agreements, which will be only to cover admissions of beneficiaries with service-connected diseases or injuries (except where the Administrator authorizes additional Government facilities to be used for nonservice-connected cases, in which event specific authorization will be granted to the manager of the office or facility concerned to utilize a particular Government hospital and except for beneficiaries in the territories and insular possessions), will not be entered into until careful consideration has been given to the best interests of both the Government and beneficiaries.

(B) (1) Private facilities will not be used for hospitalization of beneficiaries except when facilities under direct and exclusive jurisdiction of the Veterans Administration or other Federal hospitals are not feasibly available or when the physical or mental condition of beneficiaries will not allow of their transfer from a private, State or municipal hospital to a Federal hospital. Except for treatment of an emergent condition arising from a service-connected disorder, hospitalization of a male beneficiary will not be authorized in any private, State or municipal hospital whether under or not under contract. In such medically emergent cases, authorization of admission to a private, State or municipal hospital may be given, subject to the conditions stipulated in (2) hereof; and, when so given, will be authority for payment of vouchers covering the cost of such hospitalization.

#### INSTRUCTIONS TO BE ISSUED

(2) The chief medical officer or his designate, of the regional office or facility with regional office having jurisdiction of the territory in which the concerned private, State, or municipal hospital, contract or non-contract, is located, when informed of the emergent condition of the entitled beneficiary in time to authorize the hospital admission, or when requested to issue authorization to cover a hospital admission already effected, will at once notify the superintendent of such hospital as follows: (a) That payment can not be made by the Veterans Administration for any hospital service or supplies furnished prior to the date that authorization for admission had

been issued, and that such authorization can not be retroactively dated when issued; (except that authorization may be made retroactive to include a period not exceeding twenty-four hours beginning with the hour that admission to the hospital is authorized by the Veterans Administration). (b) That—if the hospital concerned is under contract with the Veterans Administration—all services and supplies furnished the beneficiary must be charged for and paid only at rates in accordance with the terms of the contract. (c) That—if the hospital concerned is not under contract—all services and supplies can be paid for only at rates in accordance with the schedule of fees, Veterans Administration. (d) That, when possible, prior authority will be requested by the hospital for the furnishing of services or supplies other than those included in a contract, or other than those comprehending ordinary items. (e) But when the procurement of such prior authority is not possible, or when the emergent condition of the beneficiary is too urgent for delay, the hospital may furnish such necessary services or supplies, with the understanding that charges therefor will be subject to determination as to their reasonable necessity by the chief medical officer or his designate.

(D) The general principles to be observed in utilization of facilities other than those over which the Veterans Administration has direct and exclusive jurisdiction will be as follows: Other Government facilities under agreements or private facilities under contracts will be used for the hospitalization of beneficiaries requiring hospital treatment for service-connected conditions in accordance with the foregoing instructions, only when facilities under direct and exclusive jurisdiction of the Veterans Administration are not feasibly available, or when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required in the individual case, make it necessary or economically advisable to utilize such other institutions instead of a facility under direct and exclusive jurisdiction of the Veterans Administration. Other Government facilities under agreement will be used for hospitalization of beneficiaries requiring treatment for nonservice-connected disease or injuries only by those offices or facilities to which the Administrator has given specific authority, and then only under the limitations defined in such authorization.

Except where prior approval of the medical director is required under the provisions of this paragraph, admissions to other Government, private, State, or municipal hospitals may be authorized by chief medical officers or their designates in regional offices and facilities with regional office activities, and by managers of insular offices.

#### CARE OF WOMEN VETERANS

(E) Women war veterans, needing treatment in a medical emergency for a condition either service-connected or not service-connected, may be authorized admission to a private hospital not under contract, if a Government or private contract facility is not feasibly available, without procurement of prior approval of the medical director. In these medically emergent cases the authority for admission to a private hospital not under contract will also be authority for payment of vouchers covering necessary services or supplies furnished in accordance with the stipulations specified in subparagraph (B) (1) hereof:

(1) Admission of a woman war veteran to a private hospital not under contract, for treatment



of a disease or injury not service-connected, when no medical emergency is existing, will not be authorized until prior approval of the medical director is secured.

(F) Managers of regional offices and facilities having regional office activities, through chief medical officers or their designates, are empowered to authorize admissions to private hospitals, under contract, of women war veterans suffering from nonservice-connected diseases or injuries, as well as service-connected conditions, in a medical emergency or otherwise, without securing prior approval of the medical director; provided that a Government facility is not feasibly available; the condition of such beneficiary, if already so hospitalized, will not safely allow of her transfer to a Government facility; or the relative travel involved in admission to a Government facility, the medical condition existing, or the nature of the treatment required, make it advisable or economical to utilize the contract facility.

(G) Pregnancy and childbirth will not entitle to hospitalization, either in facilities under direct and exclusive jurisdiction of the Veterans Administration, or in other Government, private, municipal or State Hospitals.

#### PRIOR APPROVAL NECESSARY

(H) The prior approval of the medical director must be secured for the use of private, State or municipal facilities covered by contracts, and located either within the continental limits of the United States or in the insular possessions or territories, for the hospitalization in such facilities of beneficiaries in excess of the number of beds contracted for, except where immediate hospitalization is indicated for treatment of a medically emergent service-connected disease or injury. The number of beds set apart by agreements with other Government facilities, for treatment of Veterans Administration beneficiaries may be exceeded during any month as necessitated; provided that the utilization thereof be correspondingly reduced in other months, so that the average monthly use of such beds, at the end of the fiscal year, will not have exceeded the total allocation.

(I) An applicant whose eligibility for hospitalization, (whether for observation or treatment, or whether for a service-connected or nonservice-connected condition) had been determined, whose admission to a Government facility had been authorized and who had been supplied transportation therefor but who, while en route to the designated facility (or en route from it, after completion of service and regular discharge, to the point from which he had proceeded to the hospital), develops an unavoidable and unforeseen medical emergency that forbids continuance of such travel and required admission to a private hospital or treatment by a private physician, will be entitled to such necessary services at the expense of the Government, including any extra transportation costs (ambulance or otherwise) that were actually necessitated in the circumstances. (1) If the chief medical officer or his designate of the territory concerned is informed of such emergency hospital admission or such physician's treatment before or shortly after the beginning of services, authorization for the services, followed by payment of bills therefor, may be made in accordance with the terms of (B) (2). (2) If the chief medical officer or his designate had not authorized such hospitalization or such physician's service, he may nevertheless certify for payment bills from the hospital superintendent or the attending physician, provided deter-

mination is made of the actual necessity for the items of service rendered, and payment is at fees provided in the schedule of fees, Veterans Administration. (3) Subject to the same controlling conditions as in (2), the chief medical officer or his designate may authorize reimbursement of the beneficiary or his representative if either had paid bills submitted by the superintendent of the hospital or by the physician who had attended the beneficiary, and had submitted those receipted bills.

Hospitalization in Medical Emergency—Prior authority must always be obtained for travel incident to hospital treatment or domiciliary care. Ordinarily such authority will be issued when a veteran is notified of approval of his application, and transportation, meal and lodging requests, as necessitated, are sent to him or his representative. But when an applicant's condition is medically emergent authority for travel may be extended by telephone or telegraph subject to the procedure provided therefor.

#### A.M.A. TO HOLD 1945 ANNUAL SESSION IN PHILADELPHIA, JUNE 18-22

The Ninety-Fifth Annual Session of the American Medical Association will be held in Philadelphia, June 18 to 22, 1945. This session was originally scheduled to be held in New York, June 11 to 15, but because of untoward conditions growing out of the war emergency it was found that needed facilities would not be available in that city.

Because of the tremendous demands on the hotels for rooms, physicians are asked to cooperate by refraining from making a reservation in more than one hotel, also by limiting their reservations to the minimum amount of space that they need to occupy and sharing accommodations with another physician whenever that is convenient.

#### Commission Waives Two-Year Rule In Case of Medical Officer

Acting on a petition filed in behalf of a physician serving with the armed forces, the State Industrial Commission recently approved payment of a bill for medical services which had not been filed within two years of the time the service was rendered, as required by Rule 16 of the Commission's regulations. The bill, amounting to \$10 was for an X-ray examination made on March 16, 1942, by a physician who entered military service on Oct. 21, 1942. The X-ray films were not filed with the Commission until March 17, 1944. The bill was disallowed because of the two-year rule. A reviewer took the position that the Commission should not take advantage of the application of the statute of limitations to a member of the armed forces, and recommended that the bill be paid. The Commission so ordered.

# New Names Added to Military Roster, Making Total 3,108; Those Winning Promotions Listed; County Breakdown

THE Military Roster of the Ohio State Medical Association totaled 3,108 as this issue of *The Journal* went to press. Nine names were added during the past month, making the count on Ohio physicians in the services: Army, 2,598; Navy, 436; miscellaneous services, 74. The star (\*) indicates that the man has been in service for some time but that this information has just been received by the Association. Names of those added to the roster, those promoted and a breakdown by counties, follow:

## NAMES ADDED TO MILITARY ROSTER

| Name                   | City             | Rank                    |
|------------------------|------------------|-------------------------|
| Abe, George Y.         | Cincinnati.....  | 1st Lt., U.S.A.         |
| Dexter, Morris Wm.     | Cincinnati..     | Asst. Surg., U.S.P.H.S. |
| Goldcamp, Henry Jos.   | Ironton.....     | Lt. (j.g.), U.S.N.      |
| Gollan, Frank          | Cleveland.....   | Surgeon, U.S.P.H.S.     |
| *Lehrer, David Richard | Sandusky.....    | Lt. (j.g.), U.S.N.      |
| Miller, Durard E.      | Monroeville..... | Lt. (j.g.), U.S.N.      |
| *Paternite, Carl J.    | Toledo.....      | 1st Lt., U.S.A.         |
| Ruchlman, Carl         | Cincinnati.....  | Lt., U.S.N.             |
| Vernier, Paul C.       | Columbus.....    | 1st Lt., U.S.A.         |

## WIN PROMOTIONS

| Name                  | City                   | Rank             |
|-----------------------|------------------------|------------------|
| Albert, Irwin C.      | Cincinnati.....        | Capt., U.S.A.    |
| Bartunek, Robert B.   | Shaker Heights.....    | Major, U.S.A.    |
| Best, Marshall M.     | Xenia.....             | Col., U.S.A.     |
| Bill, Herbert E.      | Cleveland.....         | Lt. Col., U.S.A. |
| Burstein, Henry A.    | Toledo.....            | Lt. Col., U.S.A. |
| Cross, Theodore A.    | Cleveland.....         | Major, U.S.A.    |
| Faessler, Edwin C.    | Cincinnati.....        | Capt., U.S.A.    |
| Ferreri, Eugene A.    | University Hgts.....   | Capt., U.S.A.    |
| Fineberg, H. M.       | Cleveland.....         | Lt. Col., U.S.A. |
| Finkelmeier, Louis    | John Cincinnati.....   | Capt., U.S.A.    |
| Gitman, Wm. H.        | Dayton.....            | Capt., U.S.A.    |
| Goughnor, Myron W.    | Akron.....             | Capt., U.S.A.    |
| Hantman, Samuel       | Cleveland.....         | Major, U.S.A.    |
| Kallenberg, Joseph B. | Cincinnati.....        | Capt., U.S.A.    |
| Krause, Geo. R.       | Cleveland.....         | Lt. Col., U.S.A. |
| Lapi, Angelo          | Canton.....            | Capt., U.S.A.    |
| McCoy, Francis W.     | Columbus.....          | Capt., U.S.A.    |
| McNerney, N. H.       | Cleveland.....         | Col., U.S.A.     |
| Meckstroth, Paul G.   | New Knoxville.....     | Major, U.S.A.    |
| Miller, Alexander     | Cleveland.....         | Lt. Col., U.S.A. |
| Sating, Robert J.     | Cleveland Heights..... | Capt., U.S.A.    |
| Solomon, Walter M.    | Cleveland.....         | Major, U.S.A.    |

## TABULATION BY COUNTIES

|                   |                   |                   |
|-------------------|-------------------|-------------------|
| Adams ..... 2     | Franklin ....247  | Madison ..... 6   |
| Allen ..... 39    | Fulton ..... 6    | Mahoning ....140  |
| Ashland ..... 12  | Gallia ..... 5    | Marion ..... 16   |
| Ashtabula .... 18 | Geauga ..... 4    | Medina ..... 13   |
| Athens ..... 10   | Greene ..... 7    | Meigs ..... 3     |
| Auglaize ..... 6  | Guernsey .... 7   | Mercer ..... 6    |
| Belmont ..... 14  | Hamilton .....507 | Miami ..... 15    |
| Brown ..... 4     | Hancock ..... 12  | Monroe ..... 1    |
| Butler ..... 30   | Hardin ..... 7    | Montgomery .163   |
| Carroll ..... 1   | Harrison ..... 4  | Morgan ..... 3    |
| Champaign .... 9  | Henry ..... 3     | Muskingum .. 9    |
| Clark ..... 37    | Highland .... 7   | Noble ..... 1     |
| Clermont ..... 9  | Hocking ..... 4   | Ottawa ..... 9    |
| Clinton ..... 8   | Holmes ..... 2    | Paulding ..... 2  |
| Columbiana ... 11 | Huron ..... 17    | Perry ..... 4     |
| Coshocton .... 4  | Jackson ..... 1   | Pickaway .... 5   |
| Crawford .... 9   | Jefferson .... 29 | Pike ..... 2      |
| Cuyahoga .....786 | Knox ..... 11     | Portage ..... 2   |
| Darke ..... 6     | Lake ..... 18     | Preble ..... 7    |
| Defiance ..... 4  | Lawrence .... 7   | Putnam ..... 6    |
| Delaware ..... 7  | Licking ..... 17  | Richland ..... 38 |
| Erie ..... 11     | Logan ..... 8     | Ross ..... 24     |
| Fairfield ..... 9 | Lorain ..... 40   | Sandusky .... 12  |
| Fayette ..... 2   | Lucas .....182    | Scioto ..... 20   |

|                  |                  |                  |
|------------------|------------------|------------------|
| Seneca ..... 12  | Tuscarawas .. 20 | Washington .. 8  |
| Shelby ..... 7   | Union ..... 2    | Wayne ..... 14   |
| Stark .....101   | Van Wert.... 9   | Williams ..... 8 |
| Summit .....165  | Vinton ..... 2   | Wood ..... 19    |
| Trumbull .... 27 | Warren ..... 4   | Wyandot ..... 8  |
| Total .....      |                  | 3108             |

## Dr. Skavlem, Cincinnati, Is Appointed Member of State Medical Board

Dr. John Harvey Skavlem, Cincinnati, has been appointed a member of the State Medical Board by Governor John W. Bricker, to fill the unexpired term of the late Dr. Claude V. Davis, Pennsville, ending March 28, 1945.

A native of Minnesota, Dr. Skavlem received his preliminary education in the public schools of Stoughton, Wisconsin, followed by a year at St. Olaf College, Northfield, Minn., and three years at the University of Wisconsin, from which he graduated in 1916 with a B.S. degree. His medical degree was conferred on him by the University of Pennsylvania School of Medicine in 1919. Two years were spent as instructor and research fellow in the Department of Anatomy with Dr. William Snow Miller at the University of Wisconsin.

Now engaged in the private practice of internal medicine in Cincinnati, Dr. Skavlem's appointments there include: associate professor of medicine, University of Cincinnati; medical director, Hamilton County Tuberculosis Hospital; attending staff, Cincinnati General Hospital, Christ Hospital (vice-president, medical staff), and Good Samaritan Hospital.

A past-president of the Cincinnati Academy of Medicine, Dr. Skavlem is a member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Physicians; Diplomate, American Board of Internal Medicine; member of council, American Trudeau Society; Director, National Tuberculosis Association; member of Board of Governors and Fellow, American College of Chest Physicians. He is a member of Phi Beta Kappa and Sigma Xi.

## Coming Meetings

Ohio State Medical Association, Columbus, May 1-3.

American Medical Association, Philadelphia, June 18-22.

American Academy of Orthopaedic Surgeons, Chicago, Jan. 21-24.

Annual Forum on Allergy, Pittsburgh, Jan. 20-21.



# Doan Appointed Dean of College of Medicine, Ohio State University; Kemp Named Professor of Public Health

**D**R. CHARLES A. DOAN is the new dean of the Ohio State University College of Medicine and director of University Hospital, Columbus. Announcement of the appointment was made Dec. 5 by President Howard L. Bevis, President of the University, following approval by the Board of Trustees.



DR. DOAN

For the past two years Ohio State's medical school has been under an acting deanship. The duties were filled by Dr. Leslie L. Bigelow until his death on Jan. 15, 1943. Since that time, the acting dean has been Dr. Rollo C. Baker, who will continue on the faculty as professor of anatomy.

Dr. Doan joined the faculty at Ohio State in 1930 as professor of medicine and director of the department of medical and surgical research. Six years later his title was changed to that of chairman of the department of medicine.

## JOHNS HOPKINS GRADUATE

Born at Nelsonville in 1896, he was graduated from high school there and then went to Hiram College, where he received a B.Sc. degree in 1918. He graduated from Johns Hopkins University School of Medicine in 1923, and continued there for a year as a resident physician and assistant in the department of anatomy.

During 1924-1925 Dr. Doan was an assistant at Harvard Medical School and assistant physician at Boston City Hospital. From 1925 until he came to Ohio State University, Dr. Doan was associated with the Rockefeller Institute of Medical Research, New York City. During World War I he was a sergeant in the Medical Corps and later he held the rank of lieutenant colonel in the Reserve Corps.

Widely known throughout the profession, particularly for his research in the field of hematology, Dr. Doan is chairman of the Committee on Scientific Work of the Ohio State Medical

Association and chairman of the Ohio-Pennsylvania region of the Wartime Graduate Medical Meetings.

## HOLDS IMPORTANT OFFICES

He is a past-president of the Ohio Public Health Association and of the Central Society for Clinical Research; is director-at-large and member of the Research Committee of the National Tuberculosis Association; Fellow of the American Medical Association, the American College of Physicians, the American Society of Clinical Pathology and the New York Academy of Medicine.

Also, he is technical director of the American Red Cross Blood Donor Center in Columbus. He is a trustee of his alma mater, Hiram College.

Dr. Kemp became dean of the Ohio State University College of Medicine, Sept. 1, 1941, having previously served in a similar capacity at the College of Medicine of the University of Vermont.

A native of Monett, Mo., he received the degree of Bachelor of Science in Medicine at St. Louis University in 1923, and became a Doctor of Medicine at the same school in 1926. He is widely known



DR. KEMP

for his work on endemic typhus and relapsing fever. His research in the latter field earned him the 1934 award of the Texas Pathological Society and the Southern Medical Association for scientific work.

## FORMER DEAN AT VERMONT

Dr. Kemp held a teaching fellowship in bacteriology at St. Louis University following his graduation there, and in 1928 he became associate professor of bacteriology and hygiene at Baylor University. In 1937 he was promoted to full professorship. He became dean at the University of Vermont in 1939. He is a member of the Ohio State Medical Association; Fellow of the American Medical Association, and member of several other scientific societies, including the Royal Society of Tropical Medicine and Hygiene, the American Association for the Advancement of Science; the American Association of Pathologists and Bacteriologists, the Society

for Experimental Biology and Medicine and the American Society for Tropical Medicine.

#### ENTERED SERVICE IN 1942

A member of the Reserve Corps of the United States Army, Dr. Kemp was called to active duty in March, 1942, and reported at the Army Medical School, Washington, D.C. He was overseas for two years, his assignments including: assistant medical director of the Trinidad Engineering District in the West Indies; assistant surgeon of the U.S. Armed Forces in Central Africa; medical inspector, China-Burma-India theater, and deputy theater surgeon of that area. At present he is executive officer of the Department of Tropical Medicine, Army Medical Center, Washington, D.C.

### Pros and Cons On Federal Medicine Presented at Welfare Meeting

At the recent Ohio Welfare Conference in Columbus, Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, addressed a general session on the subject, "How Good Is Our Nation's Health?"

The discussion was led by Robert G. Paterson, Ph.D., executive secretary of the Ohio Public Health Association.

Commenting that the session was devoted to a discussion of "governmental centralized medical service", *The Columbus Citizen* published the following report on that session of the convention:

\* \* \*

The discussion of a government centralized medical service proposal marked the second session of the 54th annual Ohio Welfare Conference today at the Deshler-Wallick Hotel.

"Socialized medical care eventually will lead to a breakdown in the nation's health", Dr. W. W. Bauer, Chicago, predicted as he went on record as opposing the proposed service.

Dr. Bauer, director of health education of the American Medical Association, told the delegates that centralized medicine would lead to a decrease in the number of physicians.

"There are many youths today waiting to see how Congress votes before deciding whether to make medicine a life-time career", he said.

The other side was presented by Dr. Robert G. Paterson, executive secretary of the Ohio Public Health Association.

"We need social cooperation of all the forces involved to keep the nation's health at its present level and to better that mark", Dr. Paterson said.

"Because the health of the nation is good or the best in the world is no reason to close our eyes or minds to any changes which will make that health better".

Dr. Bauer listed 12 fundamentals which he claims should be attained without sacrificing necessities for satisfactory medical service. They are:

- 1: It must provide medical aid promptly and without complicated official procedures.
- 2: It must not hamper the individual in choosing any doctor he wants.
- 3: It must not interfere in discontinuing the

services of one doctor or changing to another doctor without complicated official procedure.

4: It must provide all necessary treatment, hospitalization, X-rays or other necessary accessories without the necessity of dealing with any government official or other intermediary.

5: It must leave the doctor free from regulations or instructions which might interfere with free use of his professional judgment.

6: It must not limit the number of visits the doctor may make to each patient or the patients to the doctor.

7: It must cover its beneficiaries during prolonged unemployment or if permanently unemployed.

8: It must include all medical needs, leaving none outside of the scope of the plan to be provided by other means.

9: It must not require authorization other than medical for surgery or other exceptional services.

10: It must cover members of the family, other than those gainfully employed, in equal measure with those working.

11: It must be available at a fair cost, fairly distributed.

12: Its immediate or long-term effects must be such as not to dilute or deteriorate the quality of medical care available.

In upholding Federal control, Dr. Paterson offered the following facts:

1: That society recognize fully the services which the medical profession has to offer, and that society has the right to mould these services to its own ends and not in the interest of any single group.

2: That the maintenance of the "status quo" so far as the health of the people is concerned is impossible, change is the law of life and nowhere is the tempo of change more marked than in the field of health.

3: That the insidious use of words to bolster an argument has never been successful in the long run.

4: That medicine plays a large role in the total picture, but "we need a number of other disciplines which also play an important role".

5: That our people do not have the easy and prompt recourse to the medical facilities.

6: "We need a nation-wide educational program to teach our people how to use promptly and effectively the medical facilities provided in a community."

### When Silicosis Is Not Compensable

In the case of *The State, ex rel. Yuska, Appellant v. Industrial Commission of Ohio, Appellee*, No. 29978 on appeal from the Court of Appeals of Franklin County, the Ohio Supreme Court decided on Nov. 29 that under the provisions of Section 1465-68a, General Code, the General Assembly has authorized the Industrial Commission to pay compensation, medical, hospital and nursing expenses on account of silicosis in the event of temporary total disability, permanent disability and death, but that the Industrial Commission has no duty or authority to make such payment when the disability is merely partial.



# The Doctor Glares at State Medicine

By FREDERIC NELSON

(*The Saturday Evening Post*, December 9, 1944, issue)

YOUR recent doctor's bills probably shared the envelope with a leaflet warning you against "socialized medicine". The leaflet, sponsored by the National Physicians Committee, explains that, if anything like the Murray-Wagner-Dingell Social Security Bill passes, doctors will become state jobholders with no more personal interest in your tonsils than could be expected of the clerk of bills at the city hall. Friends of the medical-care sections of the Wagner Bill protest that the National Physicians Committee doesn't really represent the docs, but the fact remains that your family doctor, who is wearing himself out by his efforts to spread medical care as far as he can, thinks his number is up.

Right or wrong, this is what most doctors think, and if you doubt it, the thing to do is ask your doctor. He will probably talk your arm off, but after all you get a \$250 amputation for nothing. I can testify that there is no better way to outlast the other patients in the waiting room of a doctor's office than to stop saying "Ah" long enough to introduce some such line as this: "Doctor, I heard on the radio the other night where a fellow was explaining that only reactionaries were against this Wagner Bill". I have tried this topic on all sorts of doctors, from orthopedists to the plain general practitioner (G. P. Joe, as I suppose he will be known from now on). The result is practically always the same. My researches indicate:

1. That American doctors are against socialized medicine or any modification thereof which subordinates them to bureaucrats, makes them salaried officials or interferes with their professional standards.

2. That American doctors are definitely interested in making medical care available to more people, and in plans to pay doctors' bills on the insurance principle—provided such plans are non-political.

The fact that any group should want anything else is a complete mystery to the doctor. He is driving himself at top speed to meet the demands on him, and is baffled

by sociologists who think he could trot from bed to bed faster, if only the Federal Government would take over. Caught offguard, he is likely to give you something like this:

"You pay for your groceries, give the landlord his monthly check, and pay the undertaker a fabulous sum to bury you. But just let the doctor identify a strep infection in time, fix you up with the proper sulfa drug, and send you a bill for twenty-eight dollars, and down you sit to write to your congressman demanding that doctors be sovietized and medical expenses subsidized by the state. I don't get it."

You say, if he hasn't shut your face with a clinical thermometer: "But, doctor, there are

a lot of people who simply can't pay medical bills. Furthermore, even the average middle-class man with a good salary is knocked for a loop if he is hit by a five-hundred-dollar operation that keeps him from work for a couple of months. Nobody is blaming the doctor or expecting him to support his patients when they are flat on their backs. The problem is to find a way to help people pay for medical care, so that the doctor won't have to treat the poor for nothing, hoping against hope to land enough rich men who don't mind

**E**DITOR'S NOTE: Mr. Ben Hibbs, editor of *The Saturday Evening Post*, has granted us permission to reproduce the accompanying editorial by Frederic Nelson of his editorial staff which appeared in the December 9, 1944, issue of that magazine.

The direction which should be taken to make medical care available to more persons is charted in this wallop-packing compilation of good advice to social planners, politicians and doctors.

Those who want political medicine won't like the article; neither will those doctors who have stuck their head in the sand, thereby becoming targets for a kick in the seat of the pants.

Those who favor an evolutionary development under the leadership of doctors will like it.

The point is: Will they like it well enough to do something about getting something done, and quickly?

For example, something like the organization of a voluntary prepayment medical indemnity plan, proposed by The Council of the Ohio State Medical Association, and outlined in the December, 1944, issue of *The Ohio State Medical Journal*.

paying two thousand dollars to have an appendix lifted."

Of course, your doctor hasn't been listening. He has been waiting for you to stop talking, maybe snapping a nose elevator in the air to calm his nerves.

"You mention the people we treat free in clinics. Do you know what will happen to them under state medicine? In our clinic they get the attention of the best men in the profession. When Wagner and Murray get through with medicine, no doctor of any standing will ever see such a patient. Why? Simply because there will be a fee attached, and you can be pretty sure that some shyster with a brother-in-law at the city hall will grab all those cases."

"All right, all right", you interrupt, pushing aside the stethoscope, "but Something has got to be done."

"Sure", agrees the doc, "but understand at the outset that you are dealing with the services of highly trained professional men and not with something you can dish out over the counter at the supermarket, or, if the customers can't pay, through the Surplus Commodities Corporation."

Let's not assume from all this that the doctor has done nothing to meet new conditions. Actually, he has done quite a lot to put himself on a semicollective basis. The individual doctor can no longer afford to equip himself with all the expensive machines and gadgets used in modern practice. If he lives in a city, he probably works around a hospital where he can treat his very sick patients and consult with other doctors on cases that puzzle him. If he is a country doctor, he does the best he can. Doctors have for years grouped themselves together to feed an assembly line of diagnosis and treatment without benefit of politicians. The trouble is that relatively few laymen can afford this attention. Some crotchety doctors think the patient isn't missing much.

Because modern medical care is expensive, we have free clinics, special arrangements for the middle-class poor and a gradual extension of treatment in hospitals at standard prices. Recently, a writer in *Medical Economics* protested that hospitals were providing too much medical care administered by salaried doctors and thus presenting a menace worse than "socialized medicine". Obstetrics at flat rates, X-ray treatments, salaried anesthetists, and tonsillectomies "packaged to include surgical as well as hospital costs in one fee" were among the marketing schemes complained of. "It is time the medical profession prepared to defend the stand to which it gives lip service", said the article. "It takes more than strong language at the AMA meeting once a year to turn the tide. We are approaching a day when physicians will be merely a class of skilled laborers, readily hired and fired by their community medical centers."

To the man in the doctor's waiting room this sounds like the corner grocer worrying about the supermarket. The layman is indifferent to the dilemmas of doctors because he isn't familiar with them. At any rate, he was before the National Physicians Committee began its campaign to tell the customers how state medicine would affect them. The committee reports that its surveys reveal a trend away from socialized medicine as a result of the family doc's mild words in his own behalf.

The patients never wanted state medicine anyway, but only some sort of prepayment scheme which would make it possible for a man of modest income to pay his own medical bills. Actually, the doctors want this too. They welcome patients who carry health insurance and many of them encourage and participate in group-insurance and group-medicine plans. But they don't want a system, like that proposed in the Wagner Bill, in which the qualifications of doctors, educational standards and the right to specialize in practice are determined by a board headed by the Surgeon General.

Because he isn't much on politics, the doctor messed up his case pretty badly at first. Consequently, he got himself sued under the antitrust laws and pictured to the untutored as a leech who translates the oath of Hippocrates into English as "Never give a sucker an even break". Actually, every man knows that his own doctor is a faithful and hard-working practitioner whose personal convenience is always at the mercy of his most capricious patient. We all know doctors who perform endless labors for nothing and treat the indigent as faithfully as their few wealthy customers. But so bad have been medical public relations that advocates of state medicine have succeeded in creating a doctor who doesn't exist at all—a cold, calculating, selfish, reactionary politician whose object is to keep a very few people just well enough to pay exorbitant bills, but not healthy enough to dispense with the doctor. That picture, however, is changing. People are coming to find the bedside manner of Wagner, Murray and Dingell a little unctuous.

The doctors have more to do—and I'm passing this along to the next doctor who treats me, if the door is handy—and that is to understand a little more fully than some of them do now that the public is not much interested in socializing them, but is genuinely concerned with the costs of medical care as a real problem in the lives of most people. *Pari passu*, the social planners may as well climb down from their high horse and interest themselves in the development of medical care on evolutionary lines, and by doctors, instead of a device to make doctors into political functionaries, thereby making the lot of the patients, including the poor ones, worse instead of better.



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# A.M.A. Activities:

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Digest of News on the Current Projects,  
Programs and Services Which Are Being  
Carried on by Your National Society

FOUR representatives of the American Medical Association who testified before the Congressional Committee on Health and Wartime Education offering important data and presenting the viewpoint of the medical profession, were: Dr. Roger I. Lee, president-elect; Dr. R. L. Sensenich, member of the Board of Trustees; Dr. Harvey B. Stone, member of the Council on Medical Education and Hospitals; and Dr. Victor Johnson, secretary of that Council. Transcript of the hearings indicated that all made excellent presentations. Findings of this committee may serve as a pattern for changes in medical practice and health services in the postwar period.

\* \* \*

Sub-committees of the Committee on Postwar Medical Service have been quite active on these matters, among others: Conference with Veterans Administration officials to work out interpretation of sections of the G.I. Bill of Rights relating to postgraduate education for returning medical officers; survey of all approved hospitals to get data on how and where they can expand to provide more postgraduate and refresher training for returning medical officers.

\* \* \*

Dr. Carl Peterson, secretary of the Council on Industrial Health of the A.M.A., was a witness at hearings in Washington conducted by a sub-committee of the House Committee on Civil Service. The bill under consideration, H.R. 4909, proposes to make available to Federal Government employees the kind of medical service found generally advantageous to private industry. Dr. Peterson presented the views of the medical profession on the essential elements of good industrial health service.

\* \* \*

The new Washington office of the Council on Medical Service and Public Relations is off to a good start. A regular bulletin service to state society officers and state headquarters offices has been inaugurated, to provide them with information on happenings in Washington. Moreover, the office is filling requests from government agencies and officials for data on medical and health questions. The council is holding a series of regional meetings with state society officials and committeemen for the exchange of information and suggestions of mutual interest. Also, it is making a comprehensive study of voluntary prepayment medical care plans.

\* \* \*

Officials and committees of the A.M.A. are hard at work on plans for the 1945 Annual Session to be held June 18-22 in Philadelphia, instead of in New York as originally scheduled. Applications for space in the Scientific Exhibit are now being received by the Director, Scientific Exhibit, at the Chicago office. Those planning to attend are urged to make hotel reservations early through the committee which will be set up in Philadelphia for that purpose and will be announced soon in *The Journal of the A.M.A.*

\* \* \*

An Information Bureau has been established in the Chicago office of the A.M.A. to assemble, with the cooperation of state medical associations, data which might be of interest to physicians seeking locations or desiring to relocate. The data will cover important features of a particular community (economic, social, existing medical personnel and facilities, etc.) and will be made available to physicians on request.

\* \* \*

An official committee of the A.M.A. is working with the National Council on Physical Fitness, formulating medical standards and administrative principles on which the various states can base their programs. This means the viewpoint of the medical profession will be made known in the formation of these programs. Basic planning for the physical fitness movement will be made at the top but it will be up to state and local medical societies, and individual physicians, to see that proper programs are carried on in the different states, in line with the general suggestions made by the national group.

\* \* \*

Plans are being completed for the Seventh Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the A.M.A., at the Drake Hotel, Chicago, February 13-15. Every medical society, state or local, should, if possible, have a representative at this meeting, as industrial health and the general relations developing between medicine, labor and industry are of first rank importance.

# Health and Human Resources in Rural Ohio

A. R. MANGUS, COLUMBUS, OHIO

Department of Rural Economics and Rural Sociology, Ohio State University

## Installment No. 5 (Final)

(Continued from December, 1944, issue)

IN the preceding sections of this report we have presented in broad outline some phases of the over-all picture of the situations affecting the health and welfare of rural people. It has been recognized that since the turn of the present century unprecedented advances have been made in protecting and saving human life. In spite of this great progress there is a vast amount of human loss and impairment every year, much of which could be prevented with full application of modern knowledge and understanding.

This report has shown the need for effective programs of human conservation in such factors as:

- (1) premature deaths of infants, children, youths, and young adults
- (2) accidents, involving injuries and deaths at all ages
- (3) physical illnesses and organic impairments and defects
- (4) nervous and emotional disorders, resulting in reduced efficiency or in complete disability.

It has been shown that certain fundamental population trends and conditions are closely associated with the health situation and outlook. Among these should be mentioned the increasing age of the population with declining numbers and proportions of children, and increasing numbers and proportions of aged people, and of those in the later adult years. Large proportions of individuals carry into the later years of their lives an accumulation of defects and impairments, and in these later years are subjected to many new hazards to mental and physical health. Moreover, while increasingly large proportions of the population are surviving into the later years of life, the medical sciences have been least successful in coping with the major health problems of the later years.

The second factor of major importance from the point of view of health and human conservation is the differential reproduction rate. Those individuals who are most favored in social status, wealth, income, and education have not been reproducing themselves, while those occupying inferior social positions have been contributing disproportionately large numbers to the next generation. The social problem involved in this

**EDITOR'S NOTE:** This is the final installment of a series of articles by Mr. Mangus. In it he presents a summary of his findings and offers suggestions regarding a health policy for Ohio—primarily rural Ohio. The Journal has deemed it a privilege to have had an opportunity to present this vital study of one of Ohio's biggest problems. As has been pointed out previously, it is the responsibility of the medical profession to inform itself of conditions which have been described by Mr. Mangus and to take an active part in efforts to find solutions for them. The five installments published in *The Journal* should be filed by all readers for ready reference after they have been read thoroughly and digested.

differential reproduction is that large numbers of each succeeding generation are born and reared under inferior living conditions. The biological effects of differential reproduction have never been conclusively demonstrated, but there is some reason for believing that the genetically superior individuals in the population may not be holding their own.

A third demographic factor which is of great significance from the point of view of human conservation is that of migration of farm youths to cities. Such migration is generally selective of the better educated youths who move to cities. Moreover, the nervous and emotional strains involved in the uprooting of young people from their rural environment, and their readjustment to an entirely different way of life in the city is not always conducive to good health. Then, too, the loss of a large proportion of its youth leaves the typical farm community with an abnormal population structure and leaves disproportionately large numbers of people in the later years of life where health hazards are greatest.

Other population factors related to health include insufficient schooling on the part of rural young people, and a considerable amount of family disorganization as witnessed by widowhood, divorce, and by the considerable proportions of adult rural people who remain unmarried.

A final factor of great importance from the



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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

point of view of rural health conservation is the lack of adequate medical care and health services available to rural people. At the outset of the War per capita health needs in Ohio were in many respects as great or even greater in rural areas than in urban areas. Health services and facilities were, however, heavily concentrated in the large urban centers where they were not easily accessible to most farm and village people. Health resources in the form of professional personnel and equipment of all kinds were generally distributed, not according to actual needs but according to the effective demand for their utilization. Such demand was greater in the urban areas where people were more health conscious, where there was greater ability to pay for health services, and where more high quality services were provided free or at reduced costs to those unable to pay. Rural people in general were getting less service and a poorer quality of service due in part to lack of ability to pay the high costs of adequate medical care, or to the fear of such costs, and in part to a widespread lack of understanding and appreciation of the nature and importance of good medical and dental care.

**Toward a health policy.** Much of the loss of human life and much of the impairment in personal and social efficiency can be prevented. Proof of this is found in the wide differences in prevalence and incidence of deaths, illnesses and impairment among different groups. Such differences are found between rural and urban groups, among different level-of-living areas, and among different social and economic groups. For example, if infant death rates could be equalized at the low level already attained in certain American cities, more than 40 per cent of all infant deaths in rural Ohio could be avoided.

A coherent and consistent policy for human conservation should be based on a thorough consideration of the broader relationships of health. Medical care is now receiving much attention and rightly so. Seen in its proper perspective, however, medical care is only one part of a broader program for health conservation. The treatment and prevention of physical ill health and organic impairments is only half of the picture. The early recognition and treatment of emotional conflicts and behavior disorders deserve equal consideration. The conservation of mental health among children and youths points the way toward a major contribution to health in the later years of life. There is need for a concerted attempt to conserve mental and emotional stability, for in the field of mental health the medical man, the psychologist, the sociologist, the economist, the educator and the parent and teacher all meet on common ground.

It is no longer the practice to make a clear-cut distinction between physical ill health and

mental ill health for the human organism is after all a unit. Moreover, a great many physical ailments have their origin in mental and emotional disturbances. Medical research has discovered that impaired hearts, digestive difficulties, disturbed glands, skin diseases, and even broken bones resulting from accidents quite often trace their causes to hatreds, fears, and other emotional states. Chronic fears and anxieties which do not find outlet in normal action are often released in some form of disease. To be healthy is to be free of mental conflict and emotional turmoil.

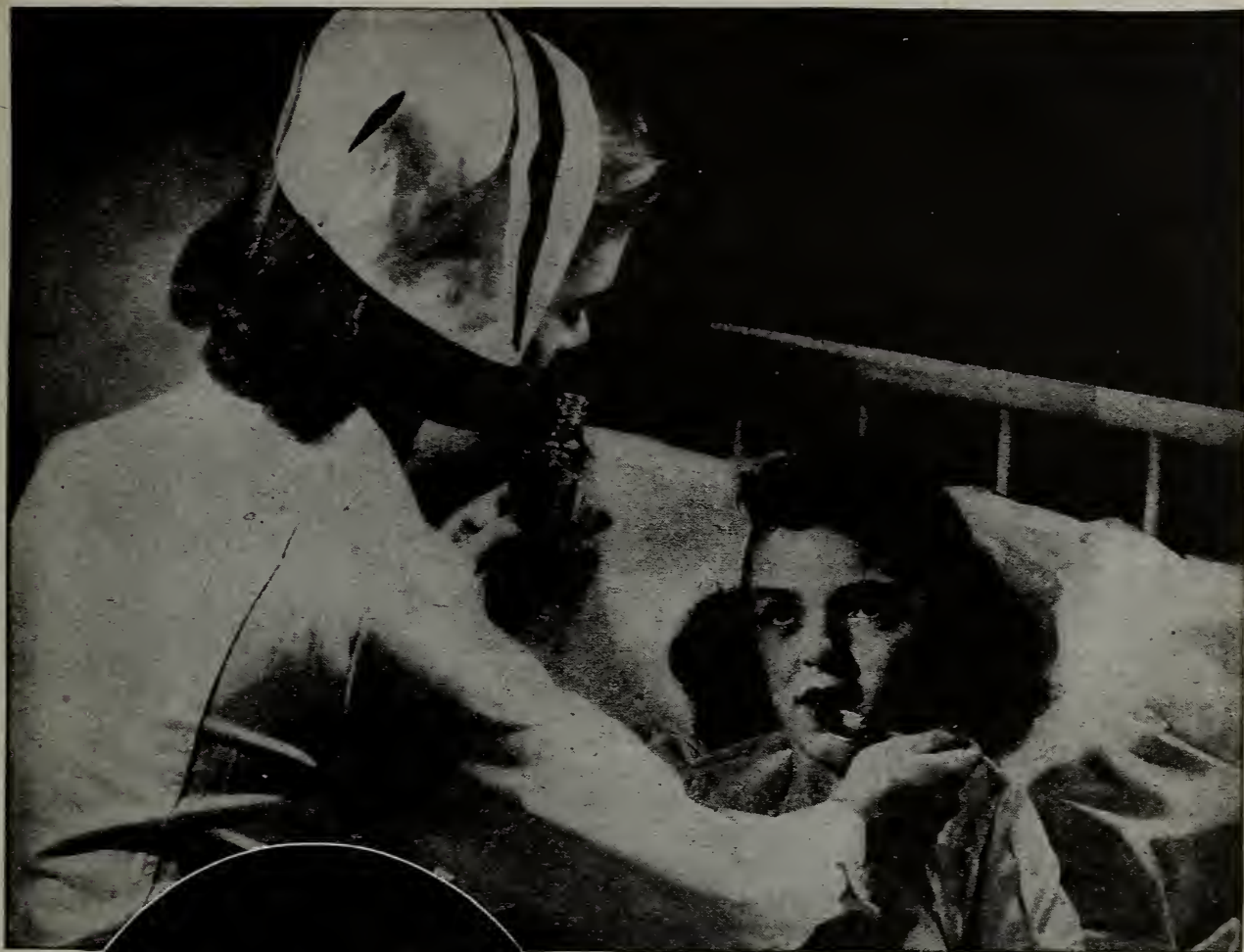
It is recognized that the problems of human health cannot be left to the comparatively few technicians and specialists in the human sciences. There is a growing need for widespread agreement on general health policies which may guide effective programs to meet present and postwar situations. The following suggestions for such policies are offered as a basis for discussion.

**1. Reducing farm to city migration.** It is believed that it would be in the interest of human health and conservation if the necessity for the migration of large numbers of farm youths could be reduced without increasing population pressure in rural areas. Such a reduction probably cannot be effected, however, so long as the great differential in reproduction between farms and cities exist. A long range policy might aim at an equalization of population fertility rates between rural and urban areas. Such an equalization of reproductivity should be at a level required for permanent population replacement, both on farms and in cities.

**2. Improving the quality of the population.** Not only is there need for discussion of policies regarding numbers and distribution of the population, but there is also need for policies directed toward the correction\* of conditions adversely affecting the quality of the population. As has been previously emphasized, much more than half of America's children are born and reared in that half of the homes that are least well-fitted socially, economically and educationally for rearing children and for providing them with maximum opportunities for development and achievement. Social and economic situations are required under which the most capable, the most intelligent, the most educated and well-adjusted persons will prefer families as large or larger than less advantaged individuals. This suggests a need for a vigorous program of family conservation. Three major steps may be suggested along this line.

a. There is need for improving the environment under which the lower one-third or one-fourth of the population normally lives. This means improvement in the food, housing, education, recreation, and income available for family living. It probably means a social security floor





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below which no family should be allowed to fall.

b. The principle of voluntary parenthood is already firmly established in that segment of the population enjoying superior educational, economic, and social advantages. It would perhaps be in the interest of human conservation if that principle were made universal in application.

c. There is a need for policies which look toward making family life more attractive. There is a particular need for mitigating economic handicaps which are now experienced by families with several children as compared to those without any children, or with only one or two. Sweden has attempted to meet this problem by providing or proposing a wide variety of community services for mothers and children. Such, for example, as free maternity services, child health services, free school lunches, rent and food subsidies to large families, and other services. There is need for a program of education for family life as well as a need for child guidance services, marriage counseling services, and parent education.

### 3. Improving medical care and health services for rural people.

a. Defining the nature of adequate medical services. In looking toward a policy for the improvement of medical services, it is necessary to get a clear understanding as to what constitutes adequate medical care. No general agreement has been reached on this matter, but it may be stated that adequacy involves the full application of the latest and best scientific knowledge and skills in medicine and related fields to the prevention, diagnosis and treatment of disease, defects, and impairments. Dentistry is recognized as an essential element in adequate medical care for serious disorders often have their origin in defective teeth.

Good medical care has a qualitative as well as a quantitative aspect. It can be had only when there are sufficient numbers of doctors, dentists, nurses and other personnel to serve the needs of all the people in a given area. It requires also adequate diagnostic and therapeutic facilities. On the qualitative side it requires medical and dental practices in accordance with the highest standards.

The Committee on the Costs of Medical Care laid down eight criteria of good medical care.<sup>23</sup>

(1) "Good medical care is limited to the practice of rational medicine based on the medical sciences.

(2) "Good medical care emphasizes prevention.

(3) "Good medical care requires intelligent cooperation between the lay public and the practitioners of scientific medicine.

(4) "Good medical care treats the individual as a whole, (including mental and emotional as well as physiological states).

(5) "Good medical care maintains a close and continuing personal relation between physician and patient.

(6) "Good medical care is coordinated with social welfare work. (This means that the physician must understand the social situation and economic needs of the patient.)

(7) "Good medical care coordinates all types of medical services.

(8) "Good medical care implies the application of all the necessary services of modern scientific medicine to the needs of all the people."

In the discussion which follows the need for medical care and health services is thought of in terms of the physical and mental conditions of rural people, and in terms of the capacities of medical science to deal with those conditions. Need is not the same, therefore, as demand because demand for medical care is limited by ability to pay and by degrees of understanding of the nature and need of health services.

#### b. Providing health education for rural people.

It is evident from the available information that there is a great discrepancy between what modern medical science has to offer, and what people, especially rural people, have been getting in the way of medical care. One reason for this discrepancy is economic, but of perhaps equal importance is the widespread lack of understanding of the nature of good medical and dental care, and of widespread existence of traditional attitudes adverse to effective health practices.

Health education aims at the development of habits, attitudes, and knowledge favorable to good physical and mental health. Such education may be carried out through the schools, the Agricultural Extension Service, public health departments, farm organizations, and especially through such local health associations as may be organized for postwar action. The content of such education should be carefully organized and planned to enlighten rural people as to the nature of the health problems which they face and to motivate them to take action leading to improvement, and conservation of both physical and mental health.

Medical practitioners also need education as to the broader social implications of medical practice.

c. Improving the quantity of rural health service and facilities. An adequate public policy for the improvement of rural health should look forward to obtaining more doctors, dentists and other health personnel in rural practice, and to increasing the amount of diagnostic and therapeutic equipment and facilities for rural people. The Committee on the Costs of Medical Care estimated the number of fully effective physicians required for adequate preventive, diag-



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nostic, and therapeutic services at 135 for each 100,000 of a typical population. Even before the War none of the level-of-living areas in Ohio had that many physicians per unit of population. That standard of adequacy was most nearly approximated in the urban-industrial area which in 1942 had the equivalent of 5,712 physicians in practice, as compared with a total of 5,974 needed to meet the standard of adequacy referred to here. In other words the number of effective physicians in that area was about 96 per cent of the number needed to meet the standard of adequacy. On the other hand the number of effective practitioners in the western-agricultural area was only about 60 per cent of the number needed; while in the transitional and southeastern areas there were less than half as many physicians per unit of population as were needed to meet the standard of 135 per 100,000 (Table 15).

beds are required per 100,000 population. On the basis of this standard of adequacy, Ohio had in 1942 only 60 per cent as many beds in registered general hospitals serving the general public as were required to meet all needs. These beds were highly concentrated, however, in the urban-industrial area where their numbers were about 77 per cent of adequacy. The western-agricultural area and the transitional area needed three times as many beds as were available, and the southeastern area had only one-fourth the number of beds as would be required to meet the standard of 462 per 100,000 population (Table 15).

No attempt has been made to estimate the shortages of auxiliary medical personnel, public health personnel, and diagnostic and therapeutic equipment in the different parts of Ohio, but such shortages do exist.

d. Improving the quality of rural health ser-

Table 15. Available and Needed Physicians, Dentists and General Hospital Beds by Areas, Ohio, 1942

| Area                 | Effective physicians       |             |                    | Dentists                   |             |                    | Hospital beds              |           |                    |
|----------------------|----------------------------|-------------|--------------------|----------------------------|-------------|--------------------|----------------------------|-----------|--------------------|
|                      | Number needed <sup>1</sup> | In practice |                    | Number needed <sup>1</sup> | In practice |                    | Number needed <sup>1</sup> | Available |                    |
|                      |                            | Number      | Pct. of No. needed |                            | Number      | Pct. of No. needed |                            | Number    | Pct. of No. needed |
| All areas            | 9,325                      | 7,514       | 80.6               | 9,672                      | 3,813       | 39.4               | 31,914                     | 19,275    | 60.4               |
| Urban-industrial     | 5,974                      | 5,712       | 95.6               | 6,196                      | 2,898       | 46.8               | 20,446                     | 15,684    | 76.7               |
| Western-agricultural | 1,824                      | 1,093       | 59.9               | 1,892                      | 535         | 28.3               | 6,242                      | 2,009     | 32.2               |
| Transitional         | 911                        | 437         | 48.0               | 945                        | 240         | 25.4               | 3,118                      | 1,065     | 34.2               |
| Southeastern         | 616                        | 272         | 44.2               | 639                        | 140         | 21.9               | 2,108                      | 517       | 24.5               |

<sup>1</sup>Estimate of need per 100,000 population: 135 physicians, 140 dentists, and 462 general hospital beds. Based on standards arrived at by the Committee on the Costs of Medical Care.

In estimating the number of dentists that would be required to adequately meet all dental needs, it is assumed that about 140 dental practitioners would be required for each 100,000 people. That standard is intermediate between the minimum of 99 and the maximum of 179 dentists per 100,000 population suggested by the Committee on the Costs of Medical Care. If this estimate of 140 dentists per unit of population is to be accepted as a standard, then in 1942 Ohio had only 39 per cent as many dental practitioners as would be needed for adequacy. This percentage of adequacy was highest in the urban-industrial area where it stood at about 47 per cent, and was lowest in the southeastern area where the number of dental practitioners was only 22 per cent of the number that would be required to fully meet dental needs. On this same basis the transitional area and the western-agricultural area needed about four times as many dentists as these areas had before the war (Table 15).

Not only were there outstanding shortages of doctors and dentists in the various areas of Ohio, but the same applied to general hospital beds. The Committee on the Costs of Medical Care arrived at the conclusion that in order to fully meet hospital needs, 462 general hospital

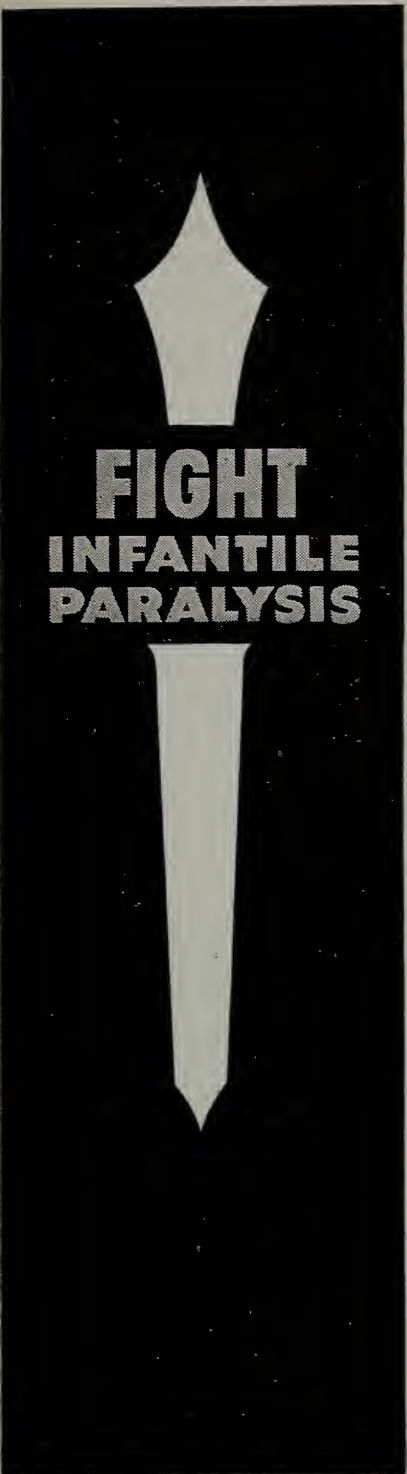
vices. Health authorities are generally agreed that the quality of rural health services may be greatly improved through the organization of community health service centers. Such centers would include a hospital for bed patients, an out-patient department or clinic for the treatment of minor illnesses, and a diagnostic-therapeutic department equipped to serve both bed patients and out-patients.

Such community institutions should be organized as voluntary non-profit agencies. They would serve to attract and hold high quality medical and dental personnel in rural areas.

Such non-profit organizations should be in a position to receive and to utilize the professional personnel and medical supplies and equipment to be disposed of by the Army and Navy Medical Corps during the demobilization period.

e. Equalizing access to medical care and health services in rural areas. The accumulation of first-rate health services and facilities in rural areas would be futile unless they could be delivered to those who need them. The spread-the-risk, share-the-cost system of payment of health and sickness expense should be applied through community health service associations. Under such a system each member contributes





## FIGHT INFANTILE PARALYSIS

# FIGHT INFANTILE PARALYSIS

This plea keynotes the great humanitarian struggle waged unceasingly by the National Foundation for Infantile Paralysis since its inception in 1938 . . . and climaxed each January by an intense public awareness and support campaign.

The vast scope of the battle against infantile paralysis — involving the time, skill and knowledge of our finest doctors and scientists — cannot be comprehended by the majority of people. However, so deep is the desire of Americans to see the obliteration of this dread disease, that they have to date contributed millions of dollars through annual March of Dimes appeals for research purposes alone.

Recognizing the importance of the work of the National Foundation, Rexall Drug Stores proudly join with the American people in support of the 1945 March of Dimes, January 14—31.

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a predetermined rate, and all receive basic benefits. In community-wide organizations contributions from employers, from private welfare organizations, or from tax-raised funds would probably be necessary to meet the needs of low-income groups and medically indigent members.

f. Making preventive services available to rural people. A major objective for planning rural health services revolves about the setting up of practical programs to lessen the incidence and severity of all illnesses and to conserve health. Such a goal calls for great improvement in rural public health programs, including those administered by public health departments, and extension of adequate school health programs to all schools, rural and urban.

Some more specific objectives are:

- (1) Detection and prevention of communicable diseases.
- (2) Continuous health inspection and periodic health examination of every school child with plans for follow-up and correction of remediable defects.
- (3) Community first-aid and home nursing programs to care for accidents and sudden illnesses.
- (4) Provision for periodic health examination in prepayment medical care plans.
- (5) Provision of a healthy environment, in the home and its surroundings, in the school and in the community generally. Services of sanitary engineers should be available to serve all rural communities.
- (6) Control and eradication of tuberculosis, Bang's disease and other diseases in farm animals which present hazards to human health.
- (7) Promotion of mental health through community-wide mental hygiene programs both for groups and for individuals.
- (8) Promotion of adequate nutrition programs.

g. Improving knowledge about the rural health situation. Rural health programs should be based on solid facts and sound principles.

Careful research is needed to provide such a base. For example, more precise information regarding rural health needs, the costs of good medical care, and the ability of rural people to pay for health services should be assembled. There is need for studies of the actuarial base for the organization of prepayment medical care plans for rural people, and of optimum geographical and population bases for rural health organization.

4. Conserving human resources. Human conservation may be taken as the major goal for a democratic society. Democratic faith has always placed great value upon the dignity and

worth of individuals. Great emphasis has been placed upon freedom and responsibility and upon the development of free and responsible persons. In spite of these democratic ideals, many recognized losses and impairments and many unsuspected handicaps have limited the freedom of individuals and have made impossible the exercise of responsibilities expected of the person in a democratic society.

From the past have come many deep-seated doubts and pessimistic or indifferent attitudes toward the preservation and development of health and effective living. The human sciences, including medicine, have recently made great advances in understanding life and what is needed to conserve and develop human possibilities. That knowledge and understanding still awaits full application, particularly in rural situations.

The goals of human conservation and health appear perfectly clear. The ways and means of reaching those goals must be fashioned out of public discussion and active experimentation. The task cannot be left to medicine alone nor to any other technical group alone. Concerted action is needed along many lines involving cooperation among many groups and agencies. Such action offers much promise for the future.

#### REFERENCE

23. Lee and Jones, *op. cit.*, pp. 6-10.

### Ohio's Medical Schools Receive Grants for Research

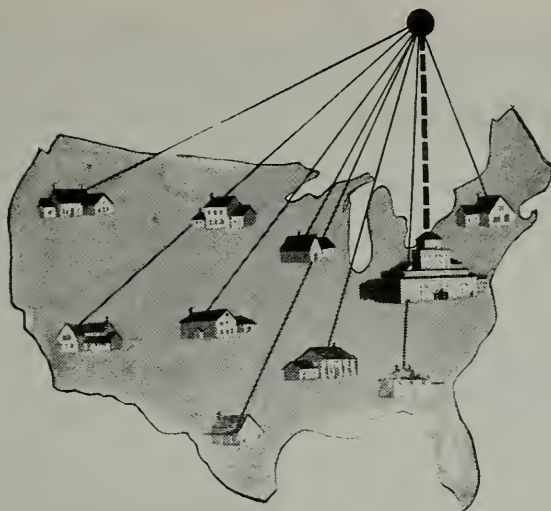
Funds for research in Ohio's three medical schools will be increased by recent grants, according to press announcements.

Swift & Company, Chicago, has made a gift of \$50,000 to the University of Cincinnati College of Medicine for a five-year study of the effect of proteins in the rehabilitation of persons disabled by nutritional deficiencies. The grant will augment the general study of nutritional diseases carried on at the University and at Hillman Hospital, Birmingham, Ala., since 1936, under the direction of Dr. Tom D. Spies, associate professor of medicine.

Abbott Laboratories, North Chicago, has granted \$5,000 to Ohio State University, for research in organic chemistry, to start one year after Germany and Japan are defeated. The gift, covering a five-year fellowship, may be used without restriction for a project in the field of medicinal products.

Cleveland friends of science and research have contributed \$5,000 anonymously to aid Dr. Harry Goldblatt's research in high blood pressure at the Western Reserve University Institute of Pathology. In announcing the gift, Dr. Howard T. Karsner, director of the Institute, stated that it would be used to expedite Dr. Goldblatt's investigation of apparent chemical causes of high blood pressure





## 9 out of 10 cases of EPILEPSY are treated in the Home

Of the more than a half-million persons in the United States who suffer from epilepsy, only about 50,000 are in public institutions.<sup>1</sup> Thus, about 90 per cent of the therapy of this disease rests on the shoulders of the physician in private practice.

Management of the epileptic in the home demands the use of therapeutic measures which will control seizures effectively, and favorably influence such psychological factors as make for better adjustment of the patient to family life, as well as to his association with others. The objective of the physician is to make it possible for the epileptic, adult or child, to live a normal life with his family.

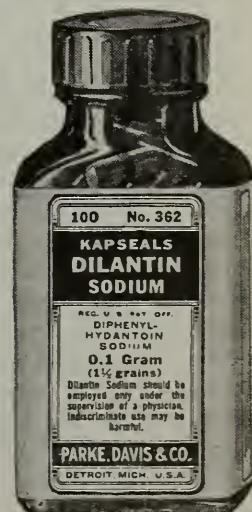
Dilantin Sodium is a superior anticonvulsant that is relatively free from hypnotic action. It is effective in many cases which fail to respond to bromides or barbiturates.

With dosage skillfully adjusted by the physician to the requirements of the individual patient, it provides complete control over seizures in a substantial percentage of cases. In others it lengthens the interval and diminishes the effect of the seizures.

1. Tracy Putnam: Convulsive Seizures, p. 4, J. B. Lippincott Co., 1943.

### DILANTIN SODIUM Diphenylhydantoin Sodium

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### PROGRESS REPORTED ON MEDICAL INSURANCE PROJECT

In the December issue of *The Journal* there appeared a report regarding the action of The Council of the Ohio State Medical Association in approving the organization by the medical profession of Ohio of a stock insurance company to provide medical coverage on a prepayment cash indemnity basis, with a close relationship in operations with the Blue Cross Hospitalization Plans.

Since that action by The Council, the Committee on Medical Service Plans has conferred with representatives of several Blue Cross Plans. A tentative schedule of principles as a base for cooperation between the proposed insurance company and the Blue Cross Plans has been formulated. Additional negotiations will be necessary before a definite announcement can be made.

Nevertheless, we are happy to say that progress has been made and, in the near future, we are of the opinion The Council will be in a position to present a specific program to the physicians of Ohio for their consideration. The confidence and help of the physicians of the state will be necessary to make the project click. The Council realizes that, so it will not delay at the proper time in presenting the matter in detailed form to the profession as a whole.

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### THEY'LL LISTEN TO YOU IF YOU'LL TALK TO THEM

Realizing that the Ohio General Assembly will convene shortly after this issue leaves the press and that the introduction of the customary number of bills on medical and health questions may be anticipated, every physician should:

Get better acquainted with those who represent his county or district in the House or Senate;

See these legislators at once; offer to advise with them on health and medical matters; suggest they consult members of the medical profession on these subjects;

Keep informed on the subject matter of proposals introduced (this can be done by keeping in touch with local legislative committeemen);

Offer his active help to his local legislative committee chairman and give such help from time to time during the session of the General Assembly.

Remember this: The legislator is primarily interested in what his own constituents think and

do. You are a constituent of at least one senator and one representative. You have a right to consult with them. They'll listen to you, if you'll just make the effort to see them and discuss matters with them. The outcome on numerous bills may hinge on how much and how effectively you talk.

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### A LABOR APPRAISAL OF CURRENT PLANNING FOR HEALTH

Why are certain labor groups for the Wagner-Murray-Dingell Bill?

Clayton W. Fountain, assistant to Walter P. Reuther, vice-president of the United Automobile Workers, C.I.O., offered this explanation in an address at the recent American Hospital Association convention in Cleveland:

"Our union, the U.A.W.-C.I.O., with a membership of well over a million workers in mass production industries, is on record in favor of the Murray-Wagner-Dingell Bill. \* \* \*

"Now we of labor know that most of the medical profession disagrees with our stand on health legislation. Many of you think that we want the state to step in and assume a dictatorial role over the distribution of medical care. You think that we want to socialize medicine and place the distribution of medical care under the blanket of bureaucracy and regimentation. You think that we want directive orders issued from Washington to tell the doctor which serum to inject into an ailing patient.

"There is a reason why you ascribe these ulterior motives to us: It is because you have not looked at the picture from our side of the fence. Let me try to explain this.

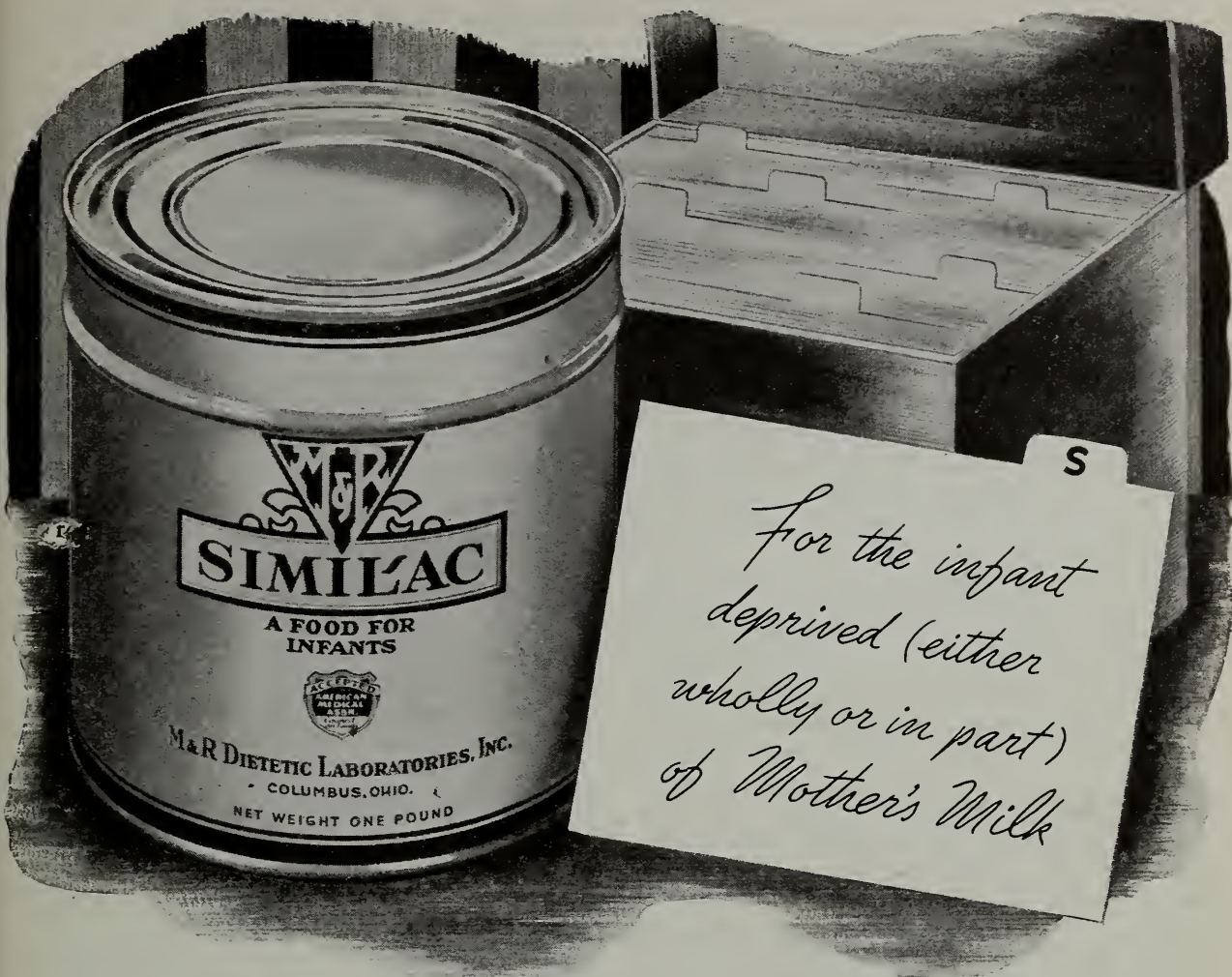
"First of all, labor does not want the state to step in and take over the direction of all social functions. This is as true of medicine as it is of any other phase of our society. We only ask for the assumption of responsibility by the state in those areas of social action where private agencies fail to do a proper and adequate job of satisfying the needs of people. \* \* \*

"So now I say that labor supports the Murray-Wagner-Dingell Bill because private agencies in the medical field are not doing a proper and adequate job of insuring the health of the common people of America. It is strictly a practical problem with us. I hope I can make that point clear.

"You will not change our minds on this issue by talking in terms of socialized medicine, bureaucracy, regimentation and all the other semantic nonsense with which this controversy has been cluttered up. What we are interested in is whether or not Joe Worker has the cash to keep himself and his family healthy—on a pay-as-you-treat basis, by prepayment, or by a system of government health insurance.

"Joe Worker wants health, and he is going to get it, one way or another; and you can not turn him aside from his quest for health by stuffing





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him with arguments against bureaucracy and regimentation. \* \* \* He knows that modern medical science can provide him with health. So, if those whose business it is to keep him healthy do not do the job to his satisfaction, he is going to turn to the state for help."

We'll go along with Mr. Fountain 100 per cent on his thesis that it won't do private agencies any good to yell bloody murder unless they offer a practical solution to the problem of helping Joe Worker meet the costs of sickness for himself and his family.

But, we disagree with some of his logic. He may not be in a mood to tolerate views which conflict with his own, but we'll argue a bit, anyway.

Mr. Fountain infers that health is entirely a question of adequacy or inadequacy of medical care. He's wrong on that point, of course. And it's a vital point.

Mr. Fountain stresses the economic aspects but has nothing to say about the quality of the services which he desires for Joe Worker. Maybe he is convinced the quality of services which the state would furnish will be as high as the quality of services by private agencies. Many will disagree with him on that point—a very important factor.

Mr. Fountain talks about looking at the picture from his side of the fence. Turn about's fair play, Mr. Fountain. Take a look at the health picture through the eyes of the doctor who lives with it 24 hours a day. It's not quite as simple a problem as some believe.

But, as he states later in his talk: "It seems foolish for us to lean on our shovels while arguing about this matter. Let us busy ourselves at the job of building a better health program even as we thrash out our differences."

We take it he means that those who don't want the state to step in had better get busy.

To that we say amen.

#### VITAMINS NOT NEEDED BY NORMAL PERSONS GETTING AVERAGE DIET

Administration of vitamin supplements to a group of apparently normal persons, consuming the usual American diet, had no demonstrable beneficial effect, a study conducted at the Duke University School of Medicine and reported in the November 25 issue of *The Journal of the A.M.A.* revealed.

As time goes on, there is an ever increasing supply of evidence to show that indiscriminate use of vitamins is not justified.

Vitamin therapy should be used only for frank deficiency diseases or suspected deficiency states when based on competent diagnosis. Over-the-counter sales to those whose condition does not indicate the need for vitamins and who should be able to secure an optimal nutrition diet should be discouraged.

#### PROGRESS MADE IN PLANS FOR POSTWAR GRADUATE MEDICAL TRAINING

Ohio physicians in the armed forces will be gratified to know that much progress is being made with respect to suitable arrangements for offering them graduate education opportunities upon their separation from the service.

As pointed out some time ago, the Committee on Education of the Ohio State Medical Association is deeply interested in this question. It is cooperating with the American Medical Association and officials of Ohio medical schools and hospitals in working out a program in Ohio which will meet the demands of returning Ohio medical officers for graduate and refresher training.

The latest development of importance on this matter is an announcement by a Subcommittee on Postwar Education of Physician Veterans of the American Medical Association that physician veterans of this war are eligible to obtain graduate education under the provisions of the so-called "G. I." bill. The announcement was made after a conference with officials of the Veterans' Administration which will administer the "G. I." bill.

This will be good news for the majority of physicians in the armed forces who have indicated on questionnaires returned to the A.M.A. that they wish graduate education, including short and long courses, in the postwar period.

It was the opinion of officials of the Veterans' Administration that the approved schools and hospitals in which the physician veterans would be taking their graduate training can be regarded as institutions eligible for recognition as educational centers in which such educational benefits might be provided under the law.

The law, as interpreted, makes it possible for any physician now in any of the branches of the service and who has been on active duty for more than 90 days to be eligible for any of the benefits provided by the law. In addition to the tuition and fee benefits, provided under the law, physicians coming under the provisions of the act also will be paid a subsistence allowance of \$50 per month if without a dependant or \$75 per month if he has a dependent. The tuition and fee benefits and the subsistence allowance will be subject to limitations which depend on the duration of service and similar factors.

A comprehensive inquiry has been transmitted by the Council on Medical Education and Hospitals of the American Medical Association to all approved hospitals, including Ohio hospitals, asking them to furnish information on the number of individuals who can be accommodated for residencies and fellowships in many fields; what new residencies can be developed; what training can be offered in basic sciences; whether short



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Since cosmetics are so universally used it is not to be wondered that they sometimes figure in the field of allergy. We venture the opinion, however, that cosmetics figure less frequently in this field than many common foodstuffs, and certainly no more frequently than many articles of clothing. Many a contact dermatitis that might formerly have been ascribed to cosmetics is now traced to dog dander, house dust, elm sap, bed linen, etc.

While our products are free from so-called common cosmetic allergens, such as orris root and rice starch, we feel it should be made clear that any of their normally innocuous ingredients might be allergenic to the allergic individual. That is why when there is a history of allergy we suggest that patch tests be made with those of our products the subject is using or contemplates using. If they test positive, further testing with their constituents is indicated to determine the offending agents. These found, we frequently can modify our formulas to suit the subject's requirements.

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term refresher courses can be offered and in what subjects; maintenance, quarters, etc.

As soon as this data has been assembled and reviewed, additional steps in definite planning and arrangements can be taken. This survey will provide helpful information for the Ohio Committee on Education and will make it possible for it to proceed with plans to assist local hospitals and county medical societies in setting up long and short courses for returning Ohio physician veterans.

Attention also is being given by the Ohio committee to the matter of reviving the post-graduate lectures of the Ohio State Medical Association for men who have remained in civilian practice, as well as for returning physician veterans. The biggest obstacle to this at present is the shortage of experienced lecturers. As soon as this problem can be solved, the Association will take definite steps to reorganize the lecture programs which proved so popular with the profession in Ohio prior to the war.

Obviously, many additional steps have to be taken to whip this large program into shape but the progress which has been made to date is encouraging.

#### PAT ON THE BACK FOR PROCUREMENT AND ASSIGNMENT PROGRAM

Under the heading "An Effective Program", *Hospitals*, official publication of the American Hospital Association, pays a well-deserved tribute to the Procurement and Assignment Service for Physicians, Dentists and Nurses. Admitting that this program was not put into effect without serious dislocation in normal hospital activities, *Hospitals* nevertheless asserts:

"It seems likely that in the postwar period it will be agreed that Procurement and Assignment for Physicians has done an excellent job in distributing the medical manpower available for civilian hospitals.\*\*\* Procurement and Assignment has not been able to cure many problems and has undoubtedly not retained all the values of normal peacetime activities. However, it increasingly appears that this agency has, over all, done a very fair job."

Those who have taken an active part in making Procurement and Assignment click should be more than pleased over this statement of commendation. It carries added meaning and weight due to the fact that it has had to interfere rather seriously at times with the functioning of most hospitals in order to make its program effective.

For the record it should be noted that a sizable portion of the credit for the success of the Procurement and Assignment program belongs to the hospitals, most of which have cooperated 100 per cent with the Procurement and Assignment representatives.

Our reason for mentioning this subject is not simply to engage in a bouquet-throwing contest

but to emphasize that the success of the Procurement and Assignment program is tangible evidence of what can be accomplished through voluntary endeavors. Those familiar with the way the Procurement and Assignment activities have been conducted in Ohio will admit, in our opinion, that persuasion rather than coercion and compulsion has been the keynote of the program, making the Ohio record all the more outstanding and reflecting greater credit on the medical, dental and nursing professions and the hospitals of this state for the sacrifices which they have made.

#### LET'S TELL 'EM WHAT WE'RE FOR, AS WELL AS WHAT WE'RE AGAINST

Addressing its remarks to hospitals, *Modern Hospital* offers this wise advice on the matter of producing a closer relationship between the hospital and the public:

"Never before have public relations loomed so large in long-range importance as right now. However, public relations are not the exclusive province of the paid expert and the wordsmith. They are the weapons available to everyone connected with hospitals and no opportunity to use them most effectively should be ignored. The most potent rostrum is not the national political platform or the nation-wide network; it is the local newspaper and the neighborhood sewing circle."

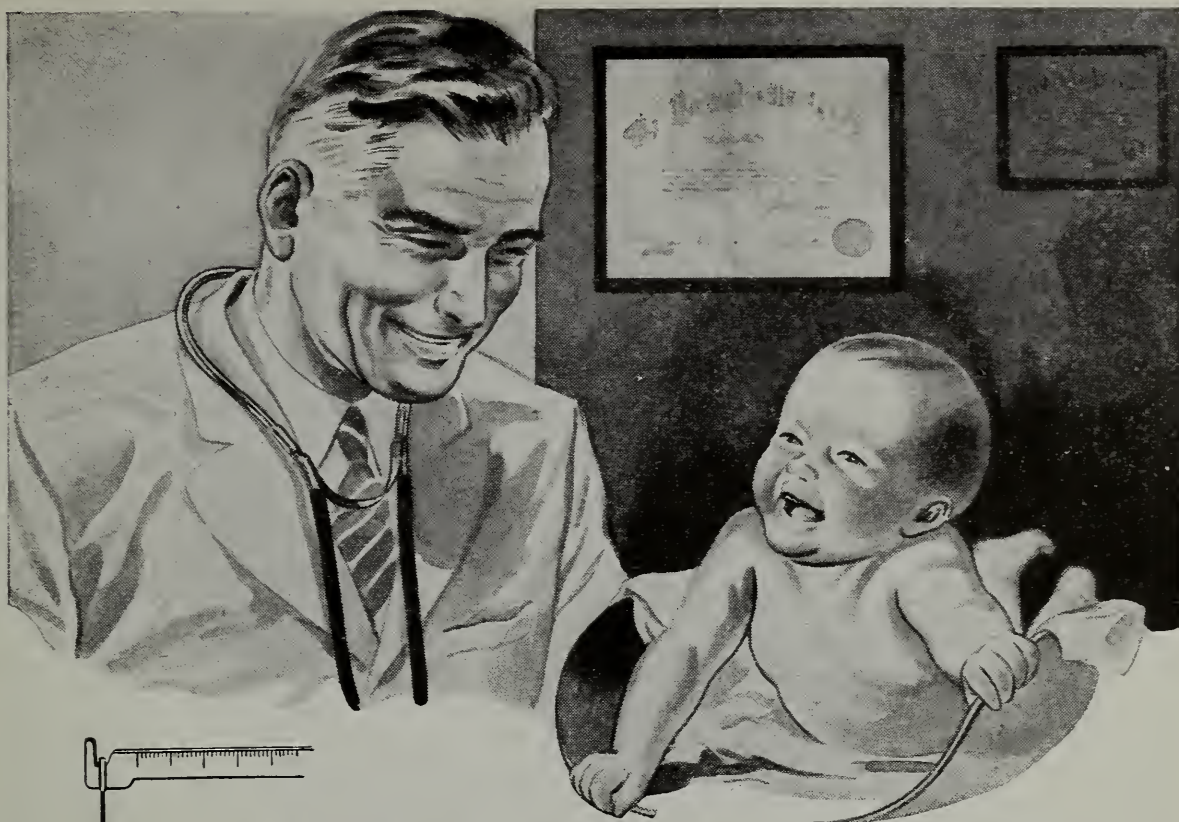
The medical profession should heed this advice, also. Use of the local newspaper by the local medical society for telling the people about the activities of the medical profession, what it stands for, what it believes is injurious to public health, etc., is too frequently ignored. Also, too many physicians appear to be "too busy" too often when asked to take a speaking assignment before a local luncheon club, civic or religious group, or similar organization.

While on the subject of public relations, there is one important point which is too often disregarded by the average physician and the average medical society, namely: The value of telling the public more frequently what the medical profession is for in the way of community efforts toward improving public health and then taking a vigorous part in making constructive suggestions actual realities.

To state the question in reverse: Too often the medical profession finds itself facing the criticism that it is more often in the "agin" column than it is in the "for" bracket.

This situation can be corrected—should be corrected. The medical profession can be—and is—for a lot of things and could propose many activities which would be beneficial to the public health. The trouble seems to be that it doesn't do enough along affirmative lines, thereby overlooking one of the best ways to win additional public esteem, to direct public opinion in the right channels and to offset the criticism that





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physicians are reactionary in their thinking and actions.

We do not imply that the medical profession should fail to speak up against those questions which it believes would be harmful to the health of the people, but we do mean that the profession ought to be just as vocal and energetic in supporting questions and programs which it believes would be beneficial to the people.

#### WHY NOT JOIN A VETERANS' ORGANIZATION NOW?

A great many Ohio physicians are eligible for membership in various veterans' organizations. Some of them are in civilian practice but have never affiliated with a veterans' group. Those now in the service will become eligible as they are separated from the service.

It is suggested that all physicians who are eligible, join one of the veterans' organizations, as it may be assumed they will be influential in shaping programs for the returning service men. Questions relating to health and medicine undoubtedly will be considered by these groups, on which they should have the medical viewpoint and advice of physicians. Physician members of the veterans' organizations will be in a position to bring about close cooperation with the medical profession in matters of mutual interest.

This is not a sales talk for the veterans' organizations but merely a suggestion as to how the medical profession can improve its public relations. It is another way for physicians to play a part in the formation of policies and programs which affect them as a profession and, perhaps, the health of a large group of citizens. Such groups need, and should have, the assistance of all eligible physicians.

#### IMPROVEMENT NEEDED IN TEACHING INDUSTRIAL HEALTH

Those who are keeping posted on current trends will agree, no doubt, that industrial health and the general relations developing between medicine, labor and industry are of first rank importance.

The subject needs a great deal of consideration by the medical profession. This is especially true with respect to medical education. Medical schools must prepare undergraduates with the basic elements of this phase of medical practice.

Progress has been made in bringing this subject into the medical school curriculum, but not enough.

A recent survey by the Council on Industrial Health of the A.M.A. shows that the average number of hours of required lectures on industrial health in the medical schools has increased

92 per cent in the period 1939 to 1943 (from slightly more than 5 hours in 1939 to 9.6 hours in 1943). One school requires 64 lecture hours; some make no provision for teaching this subject. Only a few schools make provision for clinics, demonstrations and bedside teaching. Less than half report having field trips to industry.

Ohio's three medical schools need to give this question more attention than at present. The College of Medicine, Ohio State University, requires 11 lecture hours in industrial medicine—above the average for all schools but meager in comparison to some schools. The University of Cincinnati College of Medicine requires eight lecture hours and Western Reserve University School of Medicine, three lecture hours, plus three hours of clinics and demonstrations and two field trips.

Correction of deficiencies in the time devoted to teaching industrial health is something which should be taken up by most medical schools as soon as feasible.

#### BETTER MEDICAL SUPERVISION OF ATHLETICS IS IMPERATIVE

During the recent football season we witnessed a game which demonstrated again the need for more careful medical supervision of competitive interscholastic athletics. Maybe you did, also.

The game referred to, meant a lot to the players, schools and coaches on both sides. So, influenced by the desire to win, the coach of one team used several players who, in the opinion of many, were not physically fit for the tough contest which took place.

Sure, the coach was at fault. Parents of the boys probably should have stepped in. Where were the school officials?

We might ask: Had the Board of Education provided an adequate method of medical supervision for the athletic department? If it had, the system certainly did not function.

Too much of this is going on all over Ohio, and whether you agree or not, in our opinion, some of the blame must be credited to the organized medicine profession.

If the medical society of a community will only exert its influence on school officials, these incidents will be minimized. They will occur more frequently unless the medical profession will take it upon itself to convince school authorities, coaches and parents that competent medical supervision of athletes is imperative.

Coaches want to win; so do the kids. Nevertheless, no victory is worth the gamble taken by playing an already disabled boy.

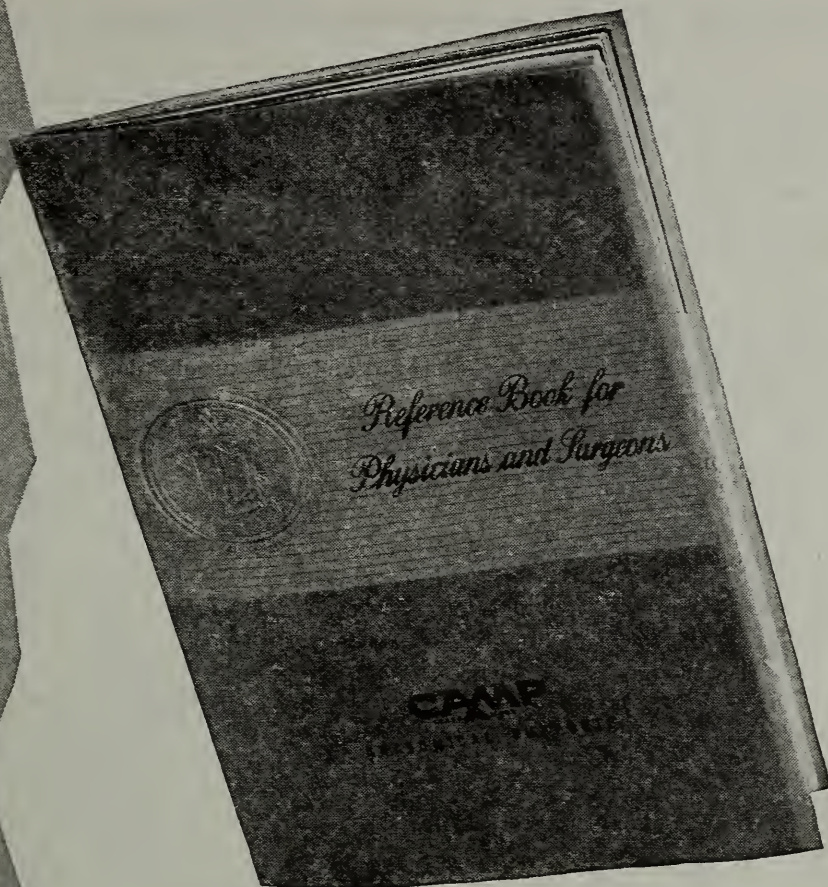
Think it over. What is your medical society doing along these lines?



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# WAR NOTES

The Public Relations Officer of the Y-Force Operations Staff in Southwestern China is becoming a regular contributor to the War Notes Section. This time he reports on Col. Paul G. Hansen, Warrensville, medical officer for a headquarters group of Y-Force Operations Staff in the field:

"Col. Hansen, in addition to caring for the Americans of the Y-Force liaison team, also treats Chinese soldiers and civilians at a daily morning sick call in the small Chinese village where he is stationed. Grateful Chinese villagers render their thanks in the form of fruit, vegetables, chickens, eggs and even pine cones, while soldiers bring Jap souvenirs to the colonel. Called to active duty with the Army in April, 1940, Col. Hansen was division surgeon for the 10th Armored Division when he was ordered to China. . . . In May the Chinese troops attacked the Japs west of the Salween River, and small Y-force liaison teams accompanied each Chinese unit to render medical and technical assistance and offer advice to the Chinese commanders. Col. Hansen went across the Salween in June. He has experienced Jap artillery fire and several times was endangered by a Jap night counter-attack. Upon one occasion he and other Y-Force officers lived for several days in an ancient Chinese temple perched on the very tip of a high mountain peak. For his service in the field with the Y-Force, Col. Hansen is entitled to wear a bronze star on his Asiatic Campaign ribbon."

\* \* \*

Capt. Nathan D. Belinsky, Youngstown, Japanese prisoner since the fall of Corregidor, is alive and well, and working in a hospital, according to an enemy propaganda broadcast picked up and transmitted to the family by the War Department.

\* \* \*

Lieut. Robert G. Smith, Columbus, sends holiday greetings from aboard one of Uncle Sam's big battle-wagons away out there in the Pacific. When Dr. Smith was in the office last March, he had two battle stars on his Pacific Theater campaign ribbon, one for Tarawa and the other for Kwajalein. Since then, he has been in action at Saipan, where his ship was torpedoed, but not sunk, by a Jap plane; Palau, Phillipines, and the tremendous sea battle with the Jap fleet in Leyte gulf.

\* \* \*

Here and there with Columbus medics: Capt. P. A. Volpe, "Somewhere in France". . . . Lt. Col. Anthony Ruppertsberg, hopes to be on his way home soon after a long sojourn on the Fiji Islands. . . . Maj. Lovell W. Rohr, a veteran

of World War I, stationed at Selfridge Field, Mich., for several months, recently transferred to Sheppard Field, Wichita Falls, Tex. . . . Capt. O. L. Coddington, wears three bronze battle stars on his ETO ribbon, one each for Normandy, Northern France and Western Germany. Says the captain: "We are hoping to put the finishing touches to this affair soon. What I have seen of Germany looks pretty much battered up and the people don't look like any super race."

\* \* \*

Maj. William L. Faul, Georgetown, is in the Replacement Pool, Stark General Hospital, Charleston, S. C. He returned to the United States recently after a year in the South Pacific, during which he participated in the New Britain and New Guinea campaigns with an evacuation hospital unit.

\* \* \*

Maj. Harry Scott and Capt. Russell Shively, Toledo, chief of the surgical service and chief of general surgery, respectively, in a general hospital in England, are roommates. The hospital is located in a Duke's estate in the Midlands. Capt. Shively has completed over two and one-half years abroad.

\* \* \*

Maj. A. D. Vogelsang, Toledo, back in the states from overseas service, is a patient at Fletcher General Hospital, Cambridge, Ohio.

\* \* \*

News about Cleveland medics from the *Bulletin of the Cleveland Academy of Medicine*: Maj. W. M. Solomon, still out in the South Pacific with the Fourth General Hospital. . . . Captain Bernard S. Malasky, at the Air Field, DeRitter, La., with the 400th Fighter Squadron. . . . Maj. Robert R. Bartunek, with a field hospital in Holland. . . . 1st Lt. Milton H. Joyce, 60th OTB, Group A, Carlisle Barracks, Pa. . . . Lt. Melvin Yeip, U.S.N., quite comfortable in present quarters on Tinian Island, after going through the excitement at Saipan. . . . Capt. James E. Slivka, home after 21 months abroad. . . . Lt. H. E. Christman, Coagaree Field, Columbia, S.C., convalescing from pneumonia. . . . Lt. Edward Eichner, home occasionally on week-ends, assigned to the Navy Recruiting Office, Pittsburgh. . . . Lt. Col. Meyer Feinberg, Aberdeen Proving Grounds, Md., after many months in the South Pacific. . . . Capt. David Fishman, Mt. Rainier Ordnance Depot, Tacoma, Wash. . . . Capt. Morton Goldhammer,



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1. Surg. Clinics of N. America, Feb., 1944. 2. J.A.M.A., 120:265, 1942.  
3. J. Lab. & Clin. Med., 28:162, 1942. 4. J.A.M.A., 119:615, 1942. 5. Med. Clinics of N. America, 27:189, Jan., 1943.

**'SULFASUXIDINE'**

*Succinylsulfathiazole*



with an air fighter base in China. . . . Capt. Joseph I. Goodman, doing internal medicine at a general hospital in England. . . . Maj. Sam Hantman, Morris Field, Charlotte, N.C. . . . Maj. Henry Hoffman, with a surgical unit of a mobile hospital, has been in the thick of it in North Africa, Sicily and now in Italy. . . . Lt. Col. Al Miller, recently married, orthopedist at Tilton General Hospital, Fort Dix, N. J. . . . Maj. Louis Pillersdorf, home on leave from overseas. . . . Capt. Robert McCaffrey, with an Eng. Avn. Bn., somewhere along the Ledo Road. Had a little difficulty after being issued canned pork, the printing on the cans being in Russian and Finnish, but issued in the Burma Theater. . . . Maj. H. P. Limbacher, with a medical battalion in Germany, now wearing the Bronze Star Medal for meritorious service and six battle stars. . . . Capt. Frank J. O'Dea, with an air service squadron, recently visited Rome and Capri. . . . Capt. Karl S. Klick, in France with a general hospital since July. . . . Lt. Comdr. Albert Glomb, U.S.N.R. Dispensary, N.A.S., fortunate to be stationed at the Country Club of the Pacific.

\* \* \*

Dr. Morton Hamburger, Jr., Cincinnati, of the Commission on Air-borne Infections, Board for the Investigation of Epidemic Diseases, Army Service Forces, recently moved from the Station Hosp., Camp Carson, Colo., to Madigan General Hospital, Fort Lewis, Wash.

\* \* \*

Lt. Col. Jerry O. Crist, Centerburg, is C. O. of the 254th General Hosp., Ft. Lewis, Wash.

\* \* \*

Out in China with a fighter control squadron is Capt. Morton L. Goldhamer, Cleveland. He left this country last May.

\* \* \*

Lt. Col. Albert M. Johnston, Marysville, formerly attached to the Gas Warfare Dept., Office of the Surgeon General, is now with the medical section of a Hq. Com. Zone, somewhere overseas.

\* \* \*

Capt. Andrew W. Cannava, Cincinnati, with an armored medical battalion in the Second Armored Division, sends a short note of appreciation from Holland.

\* \* \*

Recently returned from the Southwest Pacific, Maj. Charles C. Voorhis, Cleveland, is chief of the surgical service, Sta. Hosp., Ft. Sheridan, Ill.

\* \* \*

Group surgeon with a service group in the Marianas, Capt. Louis L. Weiss reports, cheerfully: "The rains have gone and it's a little more liveable here. We have electricity now and movies, some of which are surprisingly re-

cent. Beer is beginning to come through, but we haven't anything 'harder'. The other day we had fried eggs for breakfast and they made quite a hit."

\* \* \*

Capt. Edward I. Lederman, Baltimore, Md., a native of Cleveland and a graduate of the University of Cincinnati College of Medicine in 1941, has recently been awarded the Silver Star. The citation accompanying the award declares that "he was the assistant surgeon of an infantry battalion engaged in combat with a determined group of enemy located in advantageous positions on high ridges on Biak Island, New Guinea, May 28, 1944. Several casualties were incurred, putting a strain on the facilities of the battalion aid station. He therefore moved forward to advance units to render medical assistance with less delay. Under severe fire, he gave medical assistance to the wounded and expedited their evacuation to the rear. During withdrawal from the position across an open beach, he stopped to aid a severely wounded man. His outstanding acts required a great deal of courage and initiative, and the results of his work saved the lives of many soldiers."

\* \* \*

At a recent meeting of representatives of the professional and administrative services of the Office of the Surgeon General, plans were discussed and progress reports were made on the history of the war, work on which has been in progress since August, 1941. It is being carried out under the direction of Col. Albert G. Love, M.C., who was a member of the editorial staff that published the history of the Medical Department of the United States Army in World War I.

\* \* \*

Lt. Col. Phillip T. Knies, Columbus, Army Quarantine Liaison Officer and Assistant Director, Epidemiology Division, spoke on "Foreign Quarantine in Military Training", at a recent meeting of The American Society of Tropical Medicine in St. Louis.

\* \* \*

New assignments within the United States: Capt. R. C. Bane, Chillicothe, Sta. Hosp., Malden, Mo.; Lt. Alfred G. Allen, Cincinnati, Sta. Hosp., Scott Field, Ill.; Lt. Lincoln C. Dickey, Cleveland, SCU 1474, Camp Stewart, Ga.; Maj. R. F. Corwin, Dayton, PDC Facility, AAB, Richmond, Va.; Maj. Edw. W. Castle, Cleveland, Gardiner Gen. Hosp., Chicago, Ill.; Capt. G. E. Garvin, Blanchester, AAF, Atlanta, Ga.; Capt. Wm. M. Garrett, Frankfort, Dow Field, Bangor, Me.; Lt. John H. Graham, Hinckley, 124th Evac. Hosp., Camp Rucker, Ala.; Capt. E. M. Kilpatrick, Columbus, Madigan Gen. Hosp., Ft. Lewis.





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\*Tripoli, C. J.: The Sulfonamides in Internal Medicine, New Orleans Med. and Sur. J., 96:455-461 (April) 1944

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Wash.; Capt. Philip Katz, Toledo, AAF Reg. Hosp., Robins Field, Ga.; Capt. Angelo Lapi, Canton, Sq. "M", AAF, Muroc, Calif.; Capt. Louis W. Ladd, Jr., Cleveland, AAF, Hobbs, N. Mex.; Capt. Howard Lauer, Dayton, ASFTC, Camp Barkley, Tex.; Capt. Leon J. Malock, Youngstown, Borden Gen. Hosp., Chickasha, Okla.; Lt. Comdr. S. A. Myers, Youngstown, USN Hosp., Chelsea, Mass.; Capt. Frank Novy, Parma, AAB, Richmond, Va.; Maj. R. S. Rilling, Findlay, chief of surgical service, Sta. Hosp., Camp Rucker, Ala.; Capt. M. H. Rosenblum, Steubenville, MDETS, Billings Gen. Hosp., Ft. Benjamin Harrison, Ind.; Capt. David J. Roberts, Akron, Sta. Hosp., George Air Field, Lawrenceville, Ill.; Lt. Comdr. R. C. Schneble, USN Hosp., Yosemite, Calif.; Lt. Comdr. H. Vern Sharp, Akron, AAT&TC, Dam Neck, Va.; Capt. Henry T. Stiles, Mansfield, Ashburn Gen. Hosp., McKinley, Tex.

\* \* \*

"There's no false optimism, no complacency and no delusions about a short war among the men who are fighting the Japanese in the South Pacific", reports Lieut. Comdr. Leonard A. Stack, Lorain, home on a brief "delay en route" after ten months overseas and last stationed at a naval base on the Solomons. Dr. Stack was headed for the U. S. Naval Hospital, Bethesda, Md., for treatment.

\* \* \*

According to a news release from the Technical Information Division of the Office of the Surgeon General, the Army Medical Department has grown from 8,010 at the beginning of World War I until it now numbers 680,891. Of this number approximately 44,651 are in the Medical Corps, 14,948 in the Dental Corps, 2,012 in the Veterinary Corps, 2,364 in the Sanitary Corps, 15,078 in the Medical Administrative Corps, 59 in the Pharmacy Corps, 40,305 in the Army Nurse Corps, and there are 559,327 enlisted men, 813 Physical Therapy Aides, and 1,334 Hospital Dietitians.

\* \* \*

News about military members from the bulletin of the Miami County Medical Society: Maj. K. F. Lowry, constantly on the move with an auxiliary surgical group, "now facing the Siegfried Line and the noise and roar of artillery around us is at times deafening". . . . Maj. Lowry landed with the invasion forces on Southern France, after previous service in Italy and Africa. . . . Capt. Paul E. Foy, en route to the South Pacific with an amphibious tank battalion. . . . Maj. Hugh Wellmaier, Station Hosp., Camp Breckinridge, Ky., home recently attending his father's funeral. . . . Capt. E. R. Irvin, with a medical clearing company, landed at Cherbourg and had been near Paris—"after

quite a while in the Army, at last practicing medicine". . . . Maj. W. W. Trostel, Drew Field, Tampa, Fla., home on a short pass for the opening of the hunting season. . . . Lieut. E. R. Torrence, attached to the Fleet Marine Force, awaiting overseas transportation, in charge of X-ray in a unit composed of 22 medical officers, 3 dentists and 200 enlisted men. . . . Lt. John F. Beachler, Jr., with an Army Conv. Hosp. Unit, has crossed the equator. . . . Lieut. J. J. Kearney assigned to sea duty.

\* \* \*

Maj. Emmerich von Haam, chairman of the Department of Pathology at Ohio State University College of Medicine, assigned to the Third Army in France, has been overseas since last January. Following service as pathologist at Kennedy General Hospital, Memphis, he was transferred to Military Government, and received training at Fort Custar before going abroad. Here are some excerpts from a recent letter to his former colleagues:

"Every day brings new problems that have to be solved by evening. But when they are solved, and another 200 to 500 people have found shelter, heat, food and some type of medical care, you go to bed with the feeling of having performed some type of miracle and you sleep well.

"I am on the road four days out of six and have been to Belgium and Holland. As public health officer of the Third Army I investigate all reported cases of typhus, set up hospitals for Russians and Poles, supply civilian doctors with medicines, take care of our own men medically, and write all epidemiological reports.

"A staff of six officers and about 20 enlisted men help. It is bitter cold here, the mud is ankle deep, or more. On a recent trip into town I got lost and by mistake got too close to the Germans, who missed me, however.

"The misery of this whole region is terrific. Between camps of refugees, of displaced persons, and concentration camps of collaborationists, there is very little difference—all are tough to live in and people here mere cattle. Of course our soldiers live no better, but at least they can stand it better than babies and 80-year-old people."

\* \* \*

Capt. Max Sternlieb, Wadsworth, in France for three months, sends Christmas greetings, a new address, and wants his 1945 membership card. You should have had the card, doctor, and a letter from your Association before this *Journal* reaches you.

\* \* \*

Lieut. Col. Paul A. Paden, Cleveland, former director, Military Personnel Division, has been promoted to colonel and assigned as chief of the Personnel Service, Office of the Surgeon General, relieving Col. J. R. Hudnall, who has been assigned as executive officer of Walter Reed General Hospital, Washington, D. C. Colonel Paden has been in the Office of the Surgeon General since 1941, where he was first executive officer in the Military Personnel Division, becoming director in 1943. He graduated from the Univer-





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sity of Tennessee College of Medicine, Memphis, in 1932 and entered the service in 1934. Prior to entering the Office of the Surgeon General, Colonel Paden was executive officer of the Station Hospital at Fort Riley, Kansas.

\* \* \*

The Silver Star for "Distinguished Gallantry in Action" in an undisclosed campaign in the Mediterranean Theatre was awarded to Capt. Robert J. Sating, former resident at St. Ann's Hospital, Cleveland. Capt. Sating has been on active duty for the past 4 years, and Christmas Eve, 1944, marked his second anniversary overseas. Previous to this award, Capt. Sating received a Certificate of Commendation from the Commanding General of the 9th Division, dated May 13, 1944. This reads as follows:

"Certificate of Commendation—for outstanding and especially Meritorious Service, this Certificate of Commendation is awarded to Capt. Robert J. Sating, MC, 84th Field Artillery, 9th Division:

"Capt. Sating for 2 days and nights attended the wounded of 2 American Artillery Battalions and a British Brigade. Working tirelessly, he was conspicuous by his courage and self-sacrifice. His work materially reduced the fatalities among both American and British wounded. His actions were clearly indicative of high military standards."

\* \* \*

Lt. Comdr. Thomas F. Ross, Columbus, was recently detached from the U. S. Naval Air Station, Olathe, Kansas, for duty at sea. He had been there for six and one-half months as executive medical officer of the dispensary.

\* \* \*

More new addresses in the United States: Capt. Anthony Hendricks, Cincinnati, Sta. Hosp., Camp Hood, Texas; Lt. Jack R. Cooper, Columbus, 761st F. A. Bn. Med. Det., Camp Rucker, Ala.; Capt. Paul Corso, Salem, Oakland Reg. Hosp., Oakland, Calif.; Maj. Charles U. Hauser, Cincinnati, DeShon Gen. Hosp., Butler, Pa.; Lt. Comdr. David R. Talbot, Mansfield, Navy Recruiting Sta., Seattle, Wash.; Maj. Robert J. Tapke, Cincinnati Convl. Br. 70, Walter Reed Hosp., Washington, D. C.; Lt. Reynolds W. Wade, Jr., Toledo, 1318th SU., SAC, Camp Pickett, Va.; Capt. Courtney Jack, Cincinnati, Greensboro, N. C.; Capt. Wm. H. Gitman, Dayton, Sta. Hosp., P-W Camp, Huntsville, Tex.; Capt. Lewis V. Kogut, Cleveland, Fletcher Gen. Hosp., Cambridge.

\* \* \*

U. S. combat casualties for three years of war have reached 552,018, including 121,363 killed, according to incomplete official tabulations disclosed in Washington, Dec. 7, the third anniversary

of the attack on Pearl Harbor. Secretary of War Henry L. Stimson said Army casualties through Nov. 22, totaled 474,898, including 91,625 killed, 268,099 wounded, 58,926 missing and 56,248 prisoners of war. Of the wounded, 126,440 have returned to duty. Navy casualty figures released Dec. 7 for the Navy, Marine Corps and Coast Guard, totaled 77,120, including 29,738 dead, 33,479 wounded, 8,427 missing and 4,486 prisoners of war. A total of 359,247 prisoners of war were held within the United States on Dec. 1, the War Department reported. The prisoners include 305,648 Germans, 51,156 Italians and 2,443 Japanese. They are held at 130 base camps and 295 branch camps in all sections of the country.

\* \* \*

Maj. Boni E. Petcoff was home in Toledo recently, none the worse for many months in Iran. He hopes to be assigned to duty in Miami, Fla.

\* \* \*

Capt. Charles W. Consolo, Bellevue, is commanding a recreation center, operated by the 19th Corps, in an ancient Dutch village near the German border, according to a frontline dispatch from the Roer River Sector. One of several such establishments set up at corps and divisional levels within a short jeep-ride of the most advanced frontline positions, the center is located in a clean, comfortable old Dutch hotel, where G.I.'s on a 48-hour respite from combat duty, are given comfortable beds; facilities for hot baths in real tubs; Dutch-cooked food; a program of organized entertainment, including the latest American films, U.S.O. shows, and afternoon tea dances at which a selected group of 50 of the town's attractive young women appear faithfully each day. The story quotes Capt. Consolo as saying: "The time they can be kept here gives them a good rest physically, but it is not really long enough to get their minds off the war or to permit them to become interested in hell-raising". The center is run by medical personnel and special service troops, with a small staff of hard-working Red Cross girls, who have coffee and doughnuts available at odd hours between meals.

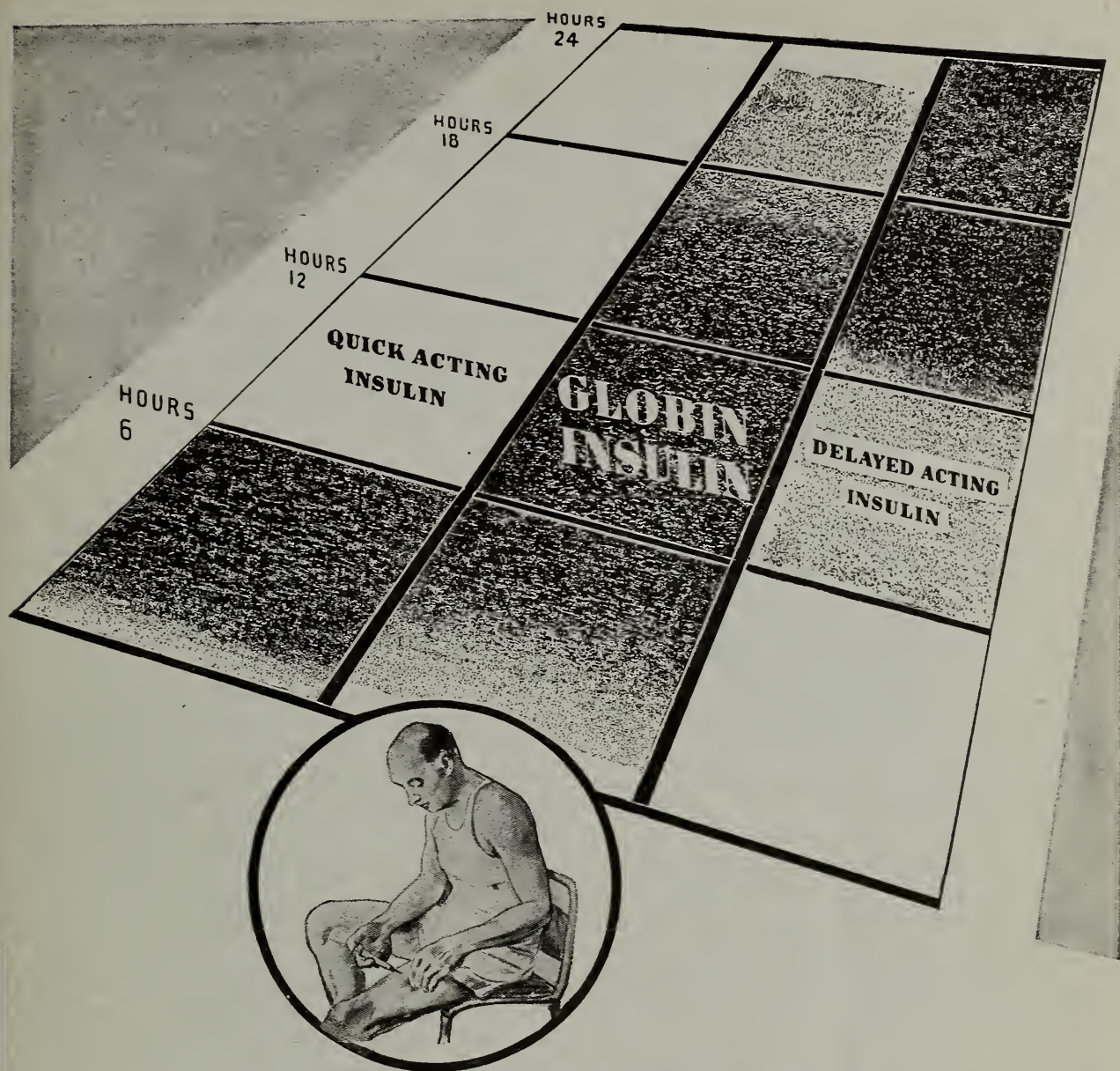
\* \* \*

A twice-wounded medical officer, Capt. Paul Hahn, Warsaw, is now in charge of the reconditioning school at Fletcher General Hospital, Cambridge, while recovering from injuries received in Sicily and the assault on Normandy. Evacuated by air to the United States, Capt. Hahn was a battalion surgeon with the 1st Division, 16th infantry. He has been awarded the Purple Heart, with an Oak Leaf Cluster.

\* \* \*

Lt. Col. Charles A. Bowers, Cleveland, on inactive status after 21 months of Army service, most of it as chief of the surgical service of a





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Port of Embarkation Hospital, Camp Patrick Henry, Va., pays this high tribute to his immediate superior, Col. Scott C. Runnels, also of Cleveland, and C. O. of the camp hospital: "I had to go to Virginia to learn the true worth of one of our professional colleagues from Cleveland. Any man who can organize and run a hospital that had only eight medical deaths and no operative deaths in 16 months in a hospital of over a thousand beds, with hundreds of patients, many of them seriously ill, is a master in his line. I salute my former C. O."

\* \* \*

Home from Italy for Thanksgiving was the lucky break of Maj. Herman C. Smith, Cleveland, who took part in the invasion of North Africa and received the Purple Heart for wounds in El Guettar in Tunisia. He had been overseas as a regimental surgeon since September, 1942.

\* \* \*

Medical officer for the V-12 students at Case School of Applied Science and John Carrol University at Cleveland, is the new assignment of Lieut. Comdr. C. B. Elliott, Painesville, after 21 months with the Seabees in the Pacific.

\* \* \*

Maj. E. L. Montgomery, Circleville, after more than four years in the service with the 37th Division, including 29 months at Guadalcanal and Bougainville, returned to this country in November for hospital treatment.

\* \* \*

After completing 16 months in England as a squadron surgeon, Capt. John A. Kramer, Ada, has been transferred from the AAF Convalescent Hospital, St. Petersburg, Fla., to Miami Beach and assigned to duty with the permanent party personnel of the surgeon's division of the AAF Redistribution Center.

\* \* \*

Brig. Gen. James S. Simmons, chief of the preventive medicine service in the Office of the Surgeon General, U. S. Army, recently stated at a meeting of the National Academy of Sciences in Washington that plans are being made for an Army Medical Research Board to continue in peacetime to seek ways to protect army health for better defense of the nation. Correlated with the proposed Army Medical Research Board, under present plans, would be a committee on Medical Research for developing within civilian institutions medical investigations of importance to the armed forces. The Army board would include one member of the civilian committee, which in turn would have one member from the Army board, to provide closest cooperation.

\* \* \*

According to Col. H. K. Moore, Chief of the Meat and Dairy Hygiene Branch, the Veterinary Corps is inspecting over 700 million pounds of foods of animal origin per month. The scope of this work may be judged from the fact that

the armed forces require each day about 19,000 cattle, 27,000 hogs, 600 calves and 5,000 sheep and lambs—all of which must be inspected to insure that it is fit for food and that it complies with army specifications as to weight, class and grade, method of processing and packaging.

\* \* \*

Lieut. Col. Durward G. Hall, MC, of Springfield, Mo., has been assigned as Director of the Military Personnel Division, Personnel Service, Office of The Surgeon General. Col. Hall has been with the Office of The Surgeon General since 1941 and prior to his new assignment was Chief of the Strategic and Logistics Planning Unit, Operations Service. Born in Cassville, Mo., Col. Hall obtained his medical degree from Rush Medical College in Chicago in 1934. A member of the Army reserve since 1935, he entered active duty as first lieutenant in 1941, was promoted to captain in the same year, to major in 1942 and later that year to lieutenant colonel.

\* \* \*

Three of the original articles appearing in the December, 1944, issue of *The Military Surgeon* were written by Ohioans. They are: "Meningococcemia: Report of Five Sporadic Cases", by Lt. Col. J. M. Hayman, Jr., Cleveland, now at Moore General Hospital, Swannanoa, N. C., but written while he was with the Fourth General Hospital in the South Pacific; "Management of Ankle Fractures and Fractures of the Tibial and Fibular Shafts at Station Hospitals and in Battle Casualty Station", by Maj. Nicholas J. Giannestras, Cincinnati, at the AAF Regional Hospital, Buckley Field, Denver, Colo., according to our records, now at the AAF Regional Hospital, Coral Gables, Fla.; "The Use of Procaine Hydrochloride with the Intra-muscular Administration of Penicillin Sodium", by Maj. William F. Shannon, Cincinnati, now located at the Station Hospital, MacDill Field, Tampa, Fla.

\* \* \*

In the War Notes section of the July issue we quoted from a letter written from Anzio on May 23 by Capt. Harry G. Lieberman, Akron, in which he "hoped to be in Rome soon". We observed that by the time the July copy was being prepared, the doctor had been in Rome and urged him "On to Berlin!". A letter written in France on Oct. 16 indicates that he is well on his way—and furthermore he has a prediction as to the probable time of his arrival in the German capital. Here's what he has to say:

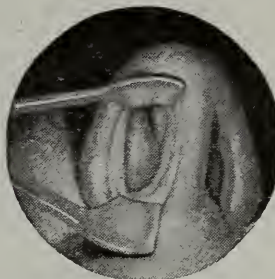
"On May 23 I predicted I'd see Rome soon. June fourth I saw the outskirts of the Eternal City and on the fifth was bunked in the Political Science Institute building on the University of Rome campus. Now ain't it the truth! 'On to Berlin!' A really good prediction. I've been in France over two months now. It looks like the arrow points to Berlin. During my 20 months as a front-line medico, I've had a varied experience, having served in infantry battalion



## ***A better means of nasal medication***

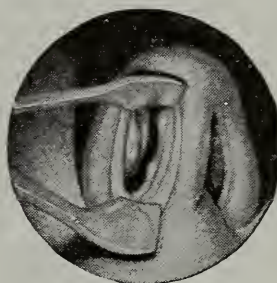
### **BEFORE TREATMENT**

Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.



### **9 MINUTES AFTER TREATMENT**

Maximum shrinkage has been obtained with 2 inhalations from Benzedrine Inhaler. The turbinates are contracted. The airway is open.



Butler and Ivy state that—for administering vasoconstrictive drugs—inhalers and sprays are preferable to nasal drops, and are—in most cases—"the better means of nasal medication," because: (1) "... the drug reaches the nasal mucosa in more diffuse form..."; (2) "... the mucosa is never severely ischemic at any one point, but the effect is spread throughout the nasal cavity..."; (3) even when prolonged medication is required, there is "... far less pathologic change than that resulting from the use of nasal drops."

Arch. Otolaryng., 39:109-123, 1944.



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(and sta.) collecting company, reconnaissance, artillery, special task force and beach aid stations, in addition to being with D-day invasion forces in Sicily, Anzio and Southern France. After serving 18 months in the Third Division, I've been assigned to the Thirty-Sixth Division, which incidentally is one helluva fine organization, too. Doc, this is a helluva war! My prediction is April, '45, for Berlin sightseeing, maybe sooner."

We'll settle for that date right now, doctor.

### Licensed Through Endorsement

During 1944, the State Medical Board granted licenses to practice medicine and surgery in Ohio to the following medical school graduates, through endorsement of their licenses to practice in other states.

Clarence F. Schubert, Zanesville, Johns Hopkins University School of Medicine; Paul E. Beare, Versailles, St. Louis University School of Medicine; Paul E. Brady, Newark, Medical College of Virginia; Alfred J. Buka, Toledo, Jefferson Medical College; Katharine Dodd, Cincinnati, Johns Hopkins University School of Medicine; Francis J. Gambrel, Youngstown, St. Louis University School of Medicine; Mary P. Hunter, Springfield, Albany Medical College; Herman P. Hyder, West Union, University of Arkansas Medical School; William H. Turner, Jr., Oberlin, University of Virginia; Robert D. McKay, Toledo, University of Illinois, Medical Department; Joseph H. Ogura, Cincinnati, University of California Medical School; Robert A. Fox, Cincinnati, Creighton University School of Medicine; Hiram J. Bazzoli, Dover, St. Louis University School of Medicine; Richard E. Jenkins, Dayton, Meharry Medical College; Samuel S. Klein, Cleveland, University of Arkansas Medical School; James B. Daley, Niles, St. Louis University School of Medicine; Powis L. Heitmeyer, Dayton, Rush Medical College, University of Chicago; Benton Holm, Dayton, Northwestern University Medical School; Jean B. R. Koupal, Toledo, Physicians and Surgeons, Columbia University; William N. Mundy, III, Toledo, Harvard Medical School; William B. Rogers, Jr., Akron, University of Maryland; Charles G. Zegiob, Lorain, University of St. Louis Medical School; Newton A. Beeton, Cincinnati, Medical College of Virginia; Stuart P. Cromer, Columbus, Northwestern University Medical School; Herman J. Kooiker, Loveland, University of Minnesota; John M. Thomas, Canton, St. Louis University School of Medicine; William J. G. Davis, Cleveland, University of Maryland; Eddie L. Dorsey, Akron, Meharry Medical College; Sidney I. Franklin, Akron, Yale University School of Medicine; Clemens M. Hartig, Cleveland, University of Kansas School of Medicine; Milo E. Holsted, Amherst, Cornell Medical College; Frederick T. LaRochelle, Cincinnati, Johns Hopkins University School of Medicine; John J. Lehner, Toledo, University of Rochester School of Medicine and Dentistry; Myron G. Means, Toledo, Rush Medical College; Cornelius M. Mezey, Akron, Royal Catholic University, Budapest, Germany; Lewis T. Mitchell, Lorain, University of the South, Medical Department; Joseph E. Moody, Columbus, University of Louisville School of Medicine; Daniel M. Murphy, Marion, St. Louis University School of Medicine; Max E. Pfeutze, Columbus, University of Kansas School of Medicine; Joseph D. Resnick, Akron, Uni-

versity of Nebraska Medical College; Marshall C. Sexton, Columbus, University of Cincinnati College of Medicine; John M. Tondra, Canton, The Creighton University; William V. Whitehorn, Columbus, University of Michigan Medical School; Paul E. Cheek, Akron, University of Louisville Medical School; Bray O. Hawk, Dover, St. Louis University School of Medicine; Ray W. Kehm, Cleveland, Jefferson Medical College; Mary T. A. Poling, Tiffin, University of Michigan Medical School; Raymond T. Saxen, Hicksville, Hahnemann Medical College; James A. Patrick, Youngstown, University of Louisville Medical School; Joseph C. Wiggins, Cleveland, Meharry Medical College; Uffee T. Jensen, Dayton, University of Iowa; Irving M. Schneider, Cleveland, New York University.

George N. Bates, Toledo, McGill University, Montreal, Quebec, Canada; Isabella B. Bourne, Cincinnati, Howard University School of Medicine; Ralph E. Brown, Jr., Columbus, Tufts College Medical School; Robert L. Burton, Akron, Meharry Medical College; Charles Chesner, Columbus, Medical School of University of Edinburgh, Edinburgh, Scotland; Eugene R. Clumpner, Cleveland, Western Reserve School of Medicine; Shelby G. Gamble, Cleveland, University of Nebraska College of Medicine; Mildred M. Hickey, Cleveland, Creighton University Medical School; William H. Kauffman, Willard, Wayne University College of Medicine; Abraham W. Marcovich, Dayton, University of Chicago; Charles S. Melzer, Springfield, University and Bellevue Hospital Medical College; Charles R. Merry, Cincinnati, Meharry Medical College; Robert E. Moffatt, Shelby, Medical College of Virginia; Pierce H. Mullally, Cleveland, St. Louis University School of Medicine; John R. Phillips, Deshler, The Medical College of South Carolina; Robert M. Rawdon, Cincinnati, Tulane University of Louisiana; Nicholas K. Ronan, Cleveland, St. Louis University School of Medicine; Richard L. Taylor, Cleveland, University of Michigan Medical School; William S. Thal, Toledo, University of Michigan Medical School; Joseph P. Webb, Cincinnati, University of Virginia Department of Medicine, Frederick A. Hemsath, Lima, Harvard University Medical School; Alexander Hersh, Columbus, University and Bellevue Hospital Medical College; Toshio Kutsunai, Cleveland, Northwestern University Medical School; Othilia V. Petrone, Columbus, Tufts College Medical School; Frank F. Tallman, Columbus, University of Alberta, Canada; M. M. Thompson, Jr., Toledo, Louisiana State University School of Medicine; Barbard B. Truex, Cincinnati, Vanderbilt University School of Medicine; Arthur J. Viehman, Cincinnati, Vanderbilt University School of Medicine; Eli J. Weller, Cleveland, The Medical College of the State of South Carolina; Salem M. Rabson, Payne, University and Bellevue Hospital Medical College.

William J. Allison, Jr., Springfield, Marquette University School of Medicine; Robert A. Borden, Crestline, University of Michigan Medical School; Elmer E. Collins, Cleveland, State University of Iowa College of Medicine; William P. Kanne, Cleveland, University of Illinois College of Medicine; Walter Mueller, Cincinnati, University of Vienna, Vienna, Austria; Raymond J. Malzone, Brecksville, R. University of Bologna, Bologna, Italy; Thomas S. Brownell, Cleveland, University of Kansas School of Medicine; James G. Tye, Dayton, University of Louisville School of Medicine; Vito C. Ancono, Cleveland, New York Medical College and Flower Hospital.



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# In Memoriam

Oscar W. Bonner, M.D., Delaware; Columbus Medical College, 1892; aged 74; former member of the Ohio State Medical Association and the American Medical Association; died Dec. 11. A practicing physician in Delaware for 44 years, Dr. Bonner was located for a short time in Norton. He was a former president of the Delaware County Medical Society and had been a member of the local board of health. Dr. Bonner was a member of the Methodist Church, Masonic Lodge and the Elks. A sister and a brother survive.

John Dean Boylan, M.D., Milford Center; Western Reserve University School of Medicine, Cleveland, 1916; aged 54; member of the Ohio State Medical Association; Fellow of the American Medical Association and the Radiological Society of North America; died Nov. 19. A former health commissioner of Union County, and prominent in community and professional affairs there, Dr. Boylan had not been well for four years. He at one time maintained an office at Marysville as well as Milford Center, and was a former president, vice-president, secretary, and delegate of the Union County Medical Society. During World War I, Dr. Boylan served overseas as a lieutenant in the Medical Corps of the U. S. Army. After the war he was health commissioner of Mahoning County. Dr. Boylan was a member of the Episcopal Church, Masonic Order, Elks Lodge, American Legion and the Kiwanis Club. Surviving are his widow, a daughter, his parents—Dr. and Mrs. John L. Boylan, Milford Center, and a sister.

Rudolph Carl Engel, M.D., Cleveland; University of Wooster, Medical Dept., Cleveland, 1902; aged 65; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Nov. 28. Dr. Engel was medical director for the Republic Steel Corporation in Cleveland, where he had practiced for 42 years. He was a member of the Masonic Order and the Knights of Pythias. Surviving are his widow and three sons, one of whom is Dr. Walter A. Engel, Cleveland.

Israel Aaron Fine, M.D., Steubenville; Ohio State University College of Medicine, 1924; aged 44; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Nov. 19. Dr. Fine practiced in Steubenville for 20 years. He was a veteran of World War I. Dr. Fine was a member of the Phi Delta Pi fraternity, the B'Nai Israel Synagogue, the B'Nai society and the Elks. Surviving are his widow, three sons, his father and mother, three sisters and a brother.

## KILLED IN ACTION

Dominic P. Caravona, M.D., Cleveland; St. Louis University School of Medicine, 1934; aged 31; member of the Ohio State Medical Association and Fellow of the American Medical Association; killed in action, near Nancy, France, Sept. 25, while serving as a captain in the Medical Corps, with an armored division. Commissioned by the Medical Officers' Recruiting Board at Cleveland in September, 1942, Capt. Caravona went overseas about ten months ago. While in general practice in Cleveland, he was a member of the visiting staffs at St. John's, Deaconess and Grace hospitals. Surviving are his widow, a daughter, a son, his parents, two sisters and a brother.

Richard Wm. Finley, M.D., Chapel Hill, N. C.; Western Reserve University School of Medicine, Cleveland, 1918; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 28. After nearly 20 years as a member of the faculty at Western Reserve, Dr. Finley went South in 1937 because of ill health. He became associated with Lakeside Hospital in 1923. In 1927 he became associate physician of the out-patient department and later was made head of the diabetic department. His widow, a daughter, a son and four sisters survive.

Lyman Greenleaf Kauffman, M.D., Dayton; Jefferson Medical College of Philadelphia, Pa., 1924; aged 44; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 12. Dr. Kauffman, who practiced in Dayton for 19 years, was senior urologist at Miami Valley Hospital, the Dayton State Hospital and visiting urologist at the Ohio Soldiers' and Sailors' Orphans' Home at Xenia. He was a member of the Phi Chi fraternity. Surviving are his widow, a son, his parents, a sister and a brother.

Edgar Lucius Langrum, M.D., Cleveland; Meharry Medical College, Nashville, Tenn., 1924; aged 46; died Nov. 25, in Los Angeles, Calif., where he had gone a year ago because of failing health. He practiced in Cleveland for 17 years. Surviving are his widow and three sisters.

Edmund O. McCollum, Tyler, Tex.; Medical College of Ohio, Cincinnati, 1892; aged 75; died Dec. 4. After practicing in Columbus 13 years,





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\*Tice, F.; "Practice of Medicine".

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Dr. McCollum went to the Southwest, and had been in Oklahoma and Texas for 34 years. He was a member of the Masonic Lodge. His widow, two daughters and a son survive.

Frank E. Plummer, M.D., Dayton; Baltimore Medical College, Baltimore, Md., 1895; aged 76; died Nov. 16. Dr. Plummer first practiced near Coalton from 1895 to 1908, when he moved to Bellefontaine. In 1922 he went to Dayton and retired from practice in 1938. He was a member of the Odd Fellows Lodge. Surviving are his widow, two daughters, a son and a sister.

Ulysses Grant Predmore, M.D., Marathon; Medical College of Ohio, Cincinnati, 1891; aged 80; died Nov. 18. A former Cincinnati physician and business man, Dr. Predmore had made his home in Clermont County for many years. Two sons survive.

Donald Grant Ralston, M.D., McConnelsville; Ohio State University College of Medicine, 1918; aged 49; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 3. A native of McConnelsville, Dr. Ralston was resident medical director of The Rocky Glen Sanatorium there for 26 years, in addition to having an extensive private practice. He was a veteran of World War I, and opened an office in McConnelsville shortly after leaving the service. Active in civic affairs, Dr. Ralston was a former mayor of the community and a member of its Board of Affairs. He was president of the Morgan County Board of Health; president and former secretary of the Morgan County Medical Society; charter member and a former president of the local Rotary Club; member of the American Legion, Masonic Lodge and the Methodist Church. Surviving are his widow and two sons; two daughters and two sons by a former marriage; his parents and a brother.

Charles Smith, M.D., Lima; Ohio State University College of Medicine, 1913; aged 61; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Nov. 16. A former coroner of Allen County, Dr. Smith practiced in Elida for four years and in Lima for the past 27 years. His widow, a daughter, a son and five brothers survive.

Frederick Kinsman Smith, M. D., Warren; University of Michigan Medical School, Ann Arbor, 1883; aged 86; former member of the Ohio State Medical Association and the American Medical Association, died Nov. 4. A practicing physician in Warren for many years, Dr. Smith was well-known throughout the state because of his active interest in Masonry. He was also active in the Episcopal Church and a few years ago presented his home to Christ Episcopal Church for use as a parsonage. A sister and a brother survive.

Frederick Wm. Watkins, M.D., Defiance; Starling Medical College, Columbus, 1895; aged 76; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 3. Dr. Watkins formerly practiced at Fultonham, Muskingum County. Surviving are his widow, two daughters and a brother.

### Civil Service Needs Physician at Cincinnati Regional Office

The U. S. Civil Service Commission is interested in securing a regional medical officer for duty in the Sixth Regional Office in Cincinnati. The physician selected will carry out, as directed by the Chief of the Regional Medical Division, a variety of duties, among them assisting in pre-placement and postplacement medical counseling service; conducting physical examinations, interviews and psychiatric examinations. The veterans' program is one of the most important features before the Commission at this time, and the handling of psychiatric cases will be a part of the duties of this position.

To qualify as an applicant, a physician must be a graduate of an approved school of medicine; have completed a general rotating internship in an approved hospital; have at least five years of progressively responsible professional experience in the field of medicine, with at least two years' experience in psychiatric medicine. The position, which pays \$5,228 per year, based on a 48-hour week, is open to men and women.

Additional details can be obtained by writing D. C. Whelan, Regional Director, U. S. Civil Service Commission, U. S. Post Office, Cincinnati.

### Join College of Surgeons

The following Ohio physicians were accepted into fellowship in the American College of Surgeons during 1944: Drs. Paul E. Adolph, Bellevue; William T. Foley, Joseph D. Heiman, Edgar H. White and Max M. Zininger, Cincinnati; Webb P. Chamberlain, Jr., Walter A. Engel and Elmer P. R. Maurer, Cleveland; I. Darin Puppel, Columbus; Paul J. Shank, Dayton; James V. Stewart, Massillon; William R. Funderburg, Tiffin; William F. Burger, Sandusky; Frank F. Jordan, Shaker Heights; Burton V. Scheib, Toledo; Albert J. Brandt, Youngstown; Clarence W. Hullinger, Springfield.

A total of 164,472 Ohioans in military service voted in the Nov. 7 election, according to a recent report of Secretary of State Edward J. Hummel. He added that 271,774 applied and that 258,333 ballots were sent out. The difference, Hummel explained, was accounted for by duplicate ballots. A total of 2,893 ballots were received too late to be counted.



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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M. D., CINCINNATI)

### BUTLER

Dr. E. O. Swartz, Cincinnati, Councilor for the First District, discussed plans of The Council for the inauguration of medical indemnity insurance in cooperation with Blue Cross, at a meeting of the Butler County Medical Society, Nov. 30, at the Middletown Hospital. At the same meeting Dr. Kurt E. Lande, pathologist at Mercy Hospital and formerly assistant medical examiner in Berlin and New York City, spoke on "Sudden Death from Natural Causes".—Azel Ames, M. D., president.

### CLINTON

The following papers were presented at a well-attended luncheon meeting of the Clinton County Medical Society, December 5, at the General Denver Hotel, Wilmington: "Women in Medicine", Dr. Elizabeth Shrieves, and "Obstetrical Emergencies", Dr. V. E. Hutchens.

Officers of the society for 1945 are: Dr. Robert Conard, Wilmington, president; Dr. L. H. Fullerton, New Vienna, vice-president; Dr. R. W. DeCrow, Wilmington, secretary-treasurer; Dr. Kelley Hale, Wilmington, chairman, Legislative Committee; Dr. R. H. Vance, Wilmington, chairman, Committee on War Participation and Committee on Recreation and Physical Fitness; Dr. DeCrow, chairman, Committee on Industrial Health.—R. W. DeCrow, M. D., secretary.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during December:

Dec. 5—Under the joint auspices of the Academy and the Cincinnati Heart Council. "Mechanism and Treatment of Shock and Allied Disorders", Dr. Eugene A. Stead, Jr., professor of medicine, Emory University Medical School, Atlanta, Ga.

Dec. 19—"Cesarean Section", Dr. Frederick C. Irving, professor of obstetrics, Harvard University Medical School, Boston, Mass.—Bulletin.

### WARREN

Officers of the Warren County Medical Society for 1945 are: Dr. Alfred Stout, Waynesville, president; Dr. O. W. Hoffman, Franklin, vice-president; Dr. Roy C. A. Bock, Lebanon, secretary, Dr. Mary Cook, Waynesville, treasurer; Dr. Robert Wilson, Franklin, chairman, Legislative Committee.—Roy C. A. Bock, M. D., secretary.

## Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

### DARKE

Officers of the Darke County Medical Society for 1945 are: Dr. J. W. Van Lue, Gettysburg, president; Dr. J. P. Gibbel, Hollansburg, vice-president; Dr. W. D. Bishop, Greenville, secretary-treasurer; Dr. A. F. Sarver, Greenville, chairman, Legislative Committee; Dr. C. J. Mills, Greenville, chairman, Committee on War Participation.—W. D. Bishop, M. D., secretary.

### MIAMI

Dr. Harry Wain, health commissioner of Miami County, reviewed vital statistics of the county, at a meeting of the Miami County Medical Society, Dec. 1, at Stouder Hospital, Troy. In addition, a few talking motion pictures to be used for lay-public health education were presented for the society's approval. The following officers were elected for the ensuing year: Dr. J. E. Bausman, Piqua, president; Dr. Russell Gardner, Troy, vice-president; Dr. George A. Woodhouse, Pleasant Hill, secretary-treasurer; Dr. J. F. Beachler, chairman, Committee on War Participation; Dr. I. C. Kiser, chairman, Legislative Committee.—G. A. Woodhouse, M.D., secretary.

### MONTGOMERY

"Treatment of Shock", was the subject discussed by Dr. P. L. Heitmeyer, at a meeting of the Montgomery County Medical Society, December 1, at Good Samaritan Hospital, Dayton. A technicolor sound film on "Caudal Anesthesia", was shown.—Don Padan, M. D., president.

## Third District

(COUNCILOR: GUY E. NOBLE, M. D., ST. MARYS)

### MERCER

Officers of the Mercer County Medical Society for 1945 are: Dr. Rudolph G. Schmidt, Celina, president; Dr. W. C. Scheidt, Celina, vice-president; Dr. A. J. Rawers, Celina, secretary-treasurer; Dr. M. L. Otis, Celina, chairman, Legislative Committee; Dr. Scheidt, chairman, Committee on War Participation; Dr. John Shea, Coldwater, chairman, Committee on Industrial Health; Dr. J. J. Otis, Celina, chairman, Committee on Recreation and Physical Fitness.—A. J. Rawers, M. D., secretary.

### VAN WERT

The following Van Wert physicians have been elected officers of the Van Wert County Medical Society for 1945: Dr. W. E. Lawhead, president; Dr. R. E. Shell, vice-president; Dr. G. A. Edwards, secretary-treasurer; Dr. C. D. Keyser,



chairman, Legislative Committee; Dr. S. A. Edwards, chairman, Committee on War Participation; Dr. Shell, chairman, Committee on Industrial Health; Dr. J. B. Sampsell, chairman, Committee on Recreation and Physical Fitness.—G. A. Edwards, M.D., secretary.

### Fourth District

(COUNCILOR: A. A. BRINDLEY, M. D., TOLEDO)  
LUCAS

The Toledo Academy of Medicine presented the following programs during December:

**Dec. 1—General Meeting.** "Medicine's Future in Washington, D. C.", Dr. Joseph Lawrence, director of the Washington office of the American Medical Association.

**Dec. 8—Eye, Ear, Nose and Throat Section.** "Diagnosis and Office Treatment of Sinusitis", Dr. Harvey C. Gunderson.

**Dec. 15—Medical Section.** "Some Practical Points in the Case of the Epileptic", Dr. L. A. Miller.—Bulletin.

### Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)  
CUYAHOGA

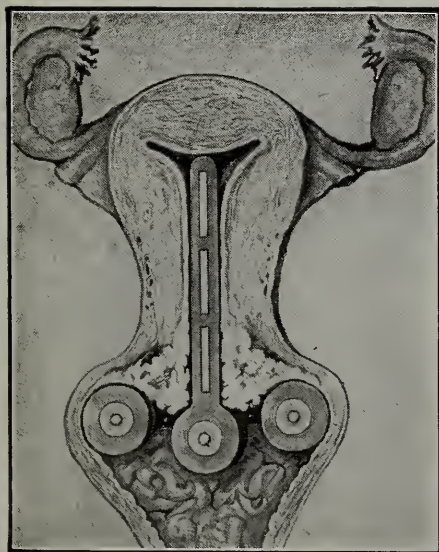
The following programs were presented by The Academy of Medicine of Cleveland during December:

**Dec. 1—Clinical and Pathological Section.** "Gastroduodenostomy in a Case of Carcinoma from Ampulla of Vater", Dr. Dwight S. Spreng; "Carcinoma of Kidney Pelvis with Nephrolithiasis", Dr. B. J. Walzak and Dr. E. R. Hexter; "Spontaneous Rupture of Pyelonephritic Kidney at Full Term Pregnancy", Dr. Rita Hain and Dr. F. S. Gibson; "Penicillin Therapy with Apparent Cure of Subacute Bacterial Endocarditis", Dr. Myron August.

**Dec. 8—Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine.** "The Metabolism and Toxicity of Sodium Citrate and Citric Acid", Jack R. Leonards, Ph.D., Alfred H. Free, Ph.D., and Victor C. Meyers, Ph.D., Dept. of Chemistry, Western Reserve University; "The Effect of Insulin on the Metabolism of Carbohydrate and Acetone Bodies by Liver Slices", Dr. Reginald A. Shipley and Dr. Edward J. Humel, Jr., Dept. of Medicine, Western Reserve University; "Studies on Ischemic Compression Shock", Dr. Harold D. Green, Dr. George A. Bergeron, and Gordon E. Gustafson, Ph.D., Depts. of Physiology and Biochemistry, Western Reserve University.

**Dec. 15—Downtown Academy Meeting.** "Practical Aspects of Protein Metabolism in Surgical Patients", Dr. Robert Elman, associate professor

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of surgery, Washington University School of Medicine, St. Louis.—Bulletin.

#### GEAUGA

Officers of the Geauga County Medical Society for 1945 are: Dr. W. A. Reed, Burton, president; Dr. H. E. Shafer, Middlefield, vice-president; Dr. Isa Teed Cramton, Burton, secretary-treasurer; Dr. Lucy Stone Hertzog, Chardon, chairman, Committee on Public Relations; Dr. W. C. Cory, Chardon, Legislative Committee-man.—Isa Teed Cramton, M.D., secretary.

#### Sixth District

(COUNCILOR: R. L. RUTLEDGE, M. D., ALLIANCE)

#### MAHONING

"Economic and Other Consequences of Growth Failure in Children", was the subject of an address made by Dr. Norman C. Wetzel, Cleveland, at a meeting of the Mahoning County Medical Society, Nov. 21, at the Youngstown Club.—Bulletin.

#### PORTAGE

Dr. Bernard H. Nichols, chief of staff of Robinson Memorial Hospital, and head of the X-ray department of the Cleveland Clinic, spoke on "Bone Sarcoma", at a meeting of the Portage County Medical Society, Dec. 7, at the Robinson Memorial Hospital, Ravenna. The following officers were elected for the ensuing year: Dr.

Joseph C. Fiala, Kent, president; Dr. Myron S. Owen, Ravenna, vice-president; Dr. Emily J. Widdecombe, Kent, secretary-treasurer.—E. J. Widdecombe, M.D., secretary.

#### SUMMIT

Dr. W. E. Froschauer, Cincinnati, spoke on "Physiology, Pathology and Treatment of the Aged", at a meeting of the Summit County Medical Society, Dec. 5, at City Hospital, Akron.—Bulletin.

#### Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)  
FRANKLIN

The Columbus Academy of Medicine presented the following programs during December:

Dec. 4—"Progress in Medicine—The 1944 Review", Dr. Bruce K. Wiseman, professor of medicine, Ohio State University College of Medicine.

Dec. 18—"Reconditioning of Returned Veterans", Maj. Peter C. Rizzo, M.C., chief of the Orthopedic Section and Officer in Charge of the Reconditioning Program, Fletcher General Hospital, Cambridge.—Bulletin.

#### Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)  
ERIE

The Annual Meeting of the Erie County Medical Society was held Dec. 7, in the society's

# 3

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new permanent headquarters in Province Hospital, Sandusky. Formal dedication of the rooms was made by Dr. Henry Lehrer, who thanked the hospital management and the physicians for their financial aid in making the new home possible. The purpose of the dinner meeting was to honor the members of the society who have practiced in Erie County 40 years or more. A short biography of the guests was presented by various members. The physicians honored were: Dr. Emily Blakeslee, Dr. Chester Bliss, Dr. Carl R. Knoble, Dr. H. C. Merz, Dr. J. D. Parker and Dr. Smith Gorsuch.—Ross M. Knoble, M.D., Councilor.

#### LORAIN

Dr. R. S. Dinsmore, Cleveland, spoke on "Tumors of the Neck", at a meeting of the Lorain County Medical Society, Dec. 12, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

### WOMAN'S AUXILIARY NEWS

(By MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee)

#### BUTLER

Mrs. C. I. Stafford entertained the members of the Woman's Auxiliary to the Butler County Medical Society at her home in Oxford, Tuesday afternoon, December 12. Mrs. Roswell S. Fidler, State President, of Columbus, Mrs. Dale P. Osborn, Past State President, Mrs. David Heusinkveld, State Secretary, of Cincinnati, and Mrs. George Wilcoxon, Past Secretary, of Wilmington, were guests on this occasion. Mrs. Wilcoxon sang several vocal numbers. Miss Margaret Gorey, Director of Nurses at Middletown Hospital, related her experiences as a nurse in China, while serving with the Rockefeller Foundation. Dr. H. A. Moore, Butler County health commissioner, chose as his subject, "A Better Community Health Program". Mrs. Harry Burdsall, president, presided at the meeting. Assisting Mrs. Stafford were Mrs. Andrew Kennedy, Mrs. Kenneth Smith, Mrs. C. T. Atkinson, Mrs. Walter Roehll, Mrs. Walter Reese, Mrs. Donald Blizzard, Mrs. Charles Macready and Mrs. Fred Brosius.

#### FRANKLIN

Members of the Woman's Auxiliary to the Columbus Academy of Medicine were guests of the Academy at a meeting on Dec. 18, at which Maj. Peter C. Rizzo, chief of the Orthopedic Section, Fletcher General Hospital, Cambridge, spoke on "Reconditioning of Returned Veterans".

#### SCIOTO

The Woman's Auxiliary to the Hempstead Academy of Medicine met at the home of Mrs. W. H. Sisson, Grandview Ave., Portsmouth, in November. Dr. C. W. Wendelken, guest speaker, gave a very instructive and informative talk on local health problems. Mrs. W. E. Gault was welcomed as a new member. Mrs. W. A. Ray

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accepted the chairmanship of war work. A Christmas party was given at the home of Mrs. Clyde Fitch in December.

#### RICHLAND

The Richland County Auxiliary has held the following meetings: Luncheon bridge at the Women's Club, Mansfield, on September 11, Mrs. L. A. Hautzenroeder, president, presiding. The members voted to pay state and national dues for each Service wife or mother who were members of the Auxiliary. On October 2, a dessert luncheon was given. Mrs. D. W. Peppard and Mrs. Edson Brown were hostesses. Mrs. J. L. Stevens introduced the speaker, Dr. George F. Linn, state legislative chairman of the Eleventh District. Dr. Linn conducted a discussion of the Miller Bill, which proved to be very interesting and instructive. On November 6, the members of the Auxiliary enjoyed a dessert luncheon at the Women's Club. Mrs. J. F. Morey and Mrs. J. M. Garber were hostesses. Miss Ruth Oesterle, Belleville, was guest speaker. Miss Oesterle's subject was the "Kellogg Foundation", explaining the purpose and functions of this health program inaugurated recently in the high schools. It is a course given to high school seniors to enable them to better acquaint themselves with matters pertaining to their own health and to urge them to have physical examinations at frequent intervals. On December 4 Mrs. Charles Brown and Mrs. C. H. Bell were in charge of arrangements for the Christmas luncheon and bridge. Mrs. L. A. Hautzenroeder, president, presided at the meeting. Mrs. J. L. Stevens gave her experiences at the National Auxiliary convention held recently in Chicago. Money was contributed by the members to purchase fruit cakes for each doctor overseas.

#### SENECA

The Woman's Auxiliary to the Seneca County Medical Society met at the home of Mrs. B. E. Williard, Tiffin, on November 9. The following officers were elected for the coming year: Mrs. Wm. Funderburg, president; Mrs. John Leahy, president-elect; Mrs. Robert E. Schriener, secretary; Mrs. N. E. Williard, treasurer. After the business meeting the group worked on Red Cross service kits, and later tables were filled for cards. Mrs. Edmund F. Ley, the retiring president, presided at the meeting.

Cleveland—New staff directors of St. John's Hospital are: Dr. John E. Hannibal, chief; Dr. J. A. Sommers, vice-chief; Dr. F. L. McGannon, secretary; Dr. F. T. Gallagher, director of surgery; Dr. W. F. Fornes, director of medicine. Named to the board of directors were Dr. Wilfred Gill and Capt. J. V. Heiman, M.C., now on active duty.



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## Program at Fletcher Hospital

A War-Time Graduate Medical Meeting devoted to the topic of "Hematology" was conducted at the Fletcher General Hospital, Cambridge, on December 7. Dr. Bruce K. Wiseman, Columbus, delivered a paper on "The Leukopenic and Leukemic States—Their Differentiation and Therapy". This was followed by a presentation of cases from the medical services by Capt. Victor H. Kugel and Capt. Newell W. Howe. "The Anemic State—Its Recognition, Importance, Various Causes and Specific Treatment" was next discussed by Dr. Charles A. Doan, Columbus. Maj. Arthur E. Rappoport presided over the round table symposium which took place during the evening session.

## New Emblem Adopted

A new Honorable Discharge Emblem has been adopted by the Army, Navy, Marine Corps and Coast Guard under an agreement signed by Secretary of War Henry L. Stimson and Secretary of the Navy James Forrestal. Made of cloth and of the same design as the Honorable Service Lapel Button, it will be sewed above the right breast pocket of all outer uniform clothing at the time of discharge. Honorably discharged personnel may wear their uniforms to their homes and thereafter at official ceremonies. The basic design of the emblem will be embroidered in gold, with the background material varying to match the color of the uniform on which it is to be worn. Supplies of the emblem are not yet available for distribution. Regulations pertinent to the Honorable Discharge Emblem will be published in the near future.

Toledo—The following physicians have been selected for membership in the American Trudeau Society: Drs. James Bayer, Howard G. Bruss, Leo V. English, James Mullen and Robert Slotterbeck.

Cincinnati—Dr. Frank F. Tallman, State Commissioner of Mental Diseases, and Dr. John Romano, head of the department of psychiatry, University of Cincinnati, College of Medicine, were the speakers at a civic luncheon of the Woman's City Club. The topic was: "Mental Health—What We Have, What We Need, and How We Can Get It".

## Program Presented by Ohio Doctors

The program for the annual postgraduate day of the Harrisburg Academy of Medicine, Nov. 16, at Harrisburg, Pa., consisted of a seminar by the following members of the faculty of the Ohio State University College of Medicine; Laurence H. Snyder, Sc.D., "Importance of the Hereditary Background in Medical Diagnosis, Prognosis, Prevention and Treatment, and Current Medical Significance of the Blood Groups, with Special Reference to the Rh. factor"; Dr. George M. Curtis, "Diseases of the Parathyroid Glands and Their Management and Surgical Considerations in Splenic Disease"; Dr. Charles A. Doan, "Differential Diagnosis and Treatment of the Anemic States and Increasing Significance of the Pathologic Physiology of the Spleen in Clinical Medicine".

Fremont—"Poliomyelitis" was the subject discussed by Dr. J. C. Boyce and Dr. C. I. Kuntz at a meeting of the Lions Club.

### CLASSIFIED ADVERTISEMENTS

Rates 50 cents per line, payable in advance. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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# Do You Know - - -

Dr. Lewis F. Smead, Toledo, became president of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons at its recent annual meeting. The next annual session will be held at Hot Springs, Va., Sept. 6-8, 1945.

\* \* \*

Mr. Ralph W. Neill, for nine years correspondent for the Associated Press Bureau at Olympia, has been chosen executive secretary of the Washington State Medical Association, succeeding the late Arthur Anderson.

\* \* \*

The latest mortality figures released by the Mexican Ministry of National Economy reveal that more Mexican patients die from diarrhea and enteritis than from any other disease. During the years 1938 to 1942, inclusive, these conditions took an average toll of 90,504 lives annually, with a mortality rate of 45.66 per 10,000. Pneumonia is in second place, with an average of 67,560 deaths annually, or a mortality of 34.12 per 10,000.

\* \* \*

The first National Public Health Nursing Day will be held throughout the country on January 26. The theme of the observance will be "Know Your Public Health Nurse—Who She Is, What She Does".

\* \* \*

Dr. Frank F. Tallman, State Commissioner of Mental Diseases, has been appointed an assistant professor of medicine at Ohio State University College of Medicine.

\* \* \*

The late Dr. Andrew P. Biddle, Detroit, former president of the Michigan State Medical Society, who died August 2, 1944, bequeathed about \$40,000 to the society's Foundation for Post-Graduate Medical Education.

\* \* \*

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, returned to Marion, his home town, Dec. 12, to address the Rotary Club. His subject was: "Present Status of Planning for the Extension of Health and Medical Services".

\* \* \*

Three Ohio physicians participated in recent conferences in New York scheduled by research committees of The American Society for Research in Psychosomatic Problems. Dr. Milton B. Cohen, Cleveland, spoke on "Allergy", Dec. 13, under the auspices of the Committee on Cutaneous and Allied Diseases, and Drs. John Romano and George L. Engel, Cincinnati, on "Delirium", at a conference held by the Committee on Physiologic Mechanisms and Animal Experimentation.

A prize of \$500 for the most valuable original paper adding to existing knowledge about the diagnosis of early glaucoma or the medical treatment of non-congestive glaucoma is being offered by the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

\* \* \*

Dr. Millard C. Hanson, city health director at Richmond, Va., has been appointed medical director for the American Red Cross in charge of the Pacific area, with headquarters in San Francisco. Dr. Hanson is a former health commissioner of Richland County and city health commissioner of Toledo.

\* \* \*

Civilian physicians are cordially invited to join with their Army colleagues in a War-Time Graduate Medical Meeting, January 23, at Crile General Hospital, Cleveland. Dr. Russell L. Haden will discuss "Polycythemia".

\* \* \*

The Ohio State Coroners' Association has been organized, and the following officers elected: E. R. Sturgis, East Liverpool, president; Dr. Robert T. Rowe, Medina, vice-president; and Dr. D. M. Ceramella, New Philadelphia, secretary-treasurer. The coroners are the last group of elective county officials to form a state association.

\* \* \*

Dr. Alice M. Bustin, Columbus, has been appointed medical member of the State Board of Cosmetology, for a term ending Nov. 1, 1947. She succeeds Maj. Thomas D. Santurello, Columbus, who has been in the Medical Corps for over two years, and is now located at Camp Pickett, Va.

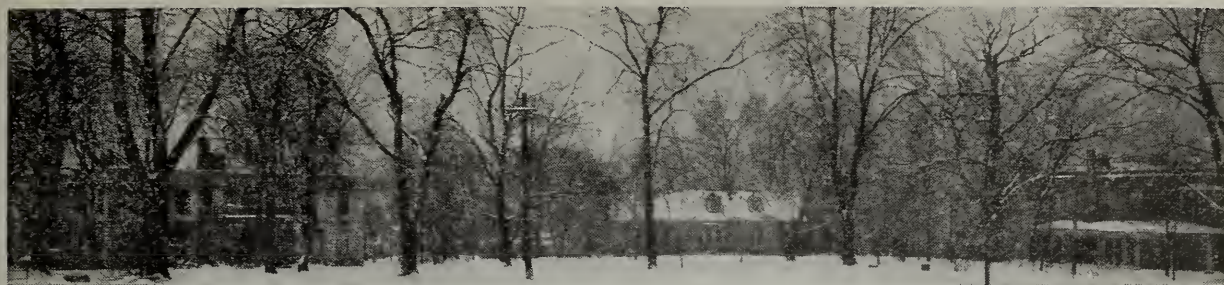
\* \* \*

There were 118,484 infant deaths in 1943 compared to 113,492 in 1942, according to the U. S. Bureau of Census. Since there were more births in 1943, the infant death rate remained virtually the same, 40.4 deaths per 1,000 live births.

\* \* \*

Now serving internships in Cincinnati hospitals, Drs. Kazuo and Kiyoshi Tashiro, two American-born sons of Dr. Shiro Tashiro, Japanese biochemist and professor at the University of Cincinnati since 1918, were among the physicians licensed to practice medicine at the November meeting of the State Medical Board. The only Japanese listed in "Who's Who", Dr. Tashiro, Sr., has a degree in medicine from Kyoto Imperial University in Japan, and B.Sc. and Ph.D. degrees from the University of Chicago. During the past two years he has helped in the war effort by teaching special classes in Japanese at the University of Cincinnati for both military personnel and civilians.





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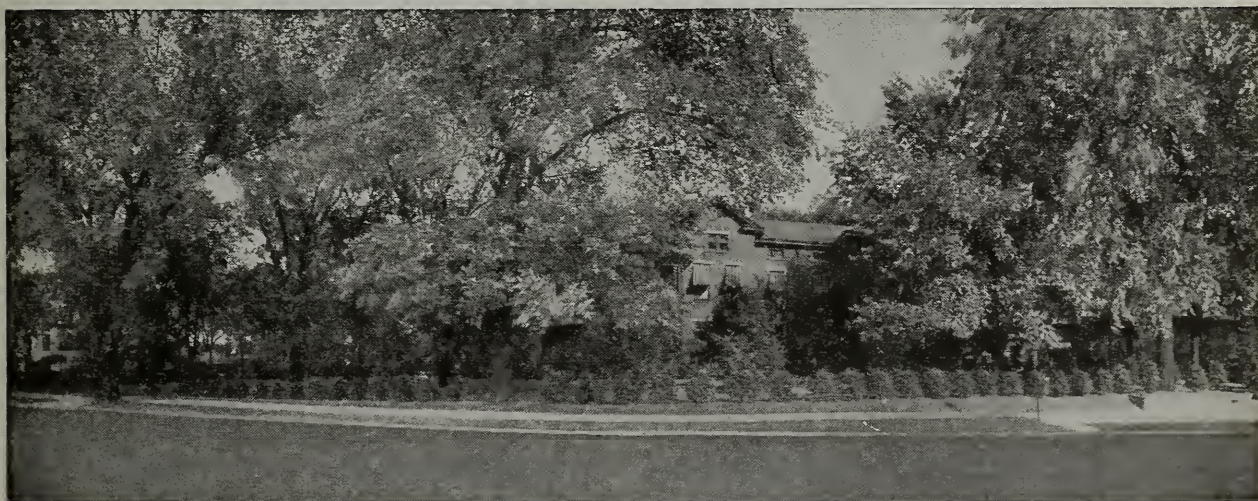
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# The Physician's Bookshelf

Freud; Master and Friend, by Hans Sachs, (\$2.50. *Harvard University Press, Cambridge, Mass.*) is a subjective and personal psychological portrait of this great psychiatrist. It has been written by the only living member of Freud's intimate circle. As a result it is a unique contribution to our knowledge of Freud.

Synopsis of Clinical Laboratory Methods, by W. E. Bray, M.D., (\$5.00. 3rd Ed. *C. V. Mosby Co., St. Louis*) brings this handy volume up to date. Such topics as the Rh factor, classification of streptococci in relation to sulfanilamide therapy may be given as an example of the new material. The sections on blood transfusion and intestinal parasites have been enlarged. There is much other new material. The book contains 93 textile illustrations and 20 colored prints, all of which have been very well chosen.

Dictionary of Gynecology and Obstetrics, by Clarence Wilbur Taber with collaboration of Mario A. Castallo, M.D., (\$3.50. *F. A. Davis Co., Philadelphia*) is a specialized medical dictionary designed for all who are interested in this special field. The value of the lexicon is simply, therefore, what you want unencumbered by hundreds of ideas that are not related. For workers in this field and for their secretaries this is a most helpful volume. Not only are the definitions well done but in many instances they become encyclopedic for the little volume contains an immense amount of material.

Ourselves Unborn, by George W. Corner, M.D., (\$3.00. *Yale University Press, New Haven, Conn.*) is an account of what happens to man before he is born, presented so that the layman can read it. This complete outline of the vicissitudes of the pre-natal cells by such an authority is an important document for any member of the human race.

Physiology in Health and Disease, by Carl J. Wiggers, M.D., (\$10.00. 4th Ed. *Lea & Febiger, Philadelphia*) has been thoroughly brought up to date to include not only the physiological analysis of disease but the interpretation of those experiences which war inflicts. The author is professor of physiology, Western Reserve University, Cleveland, and this revision has been made in his usual thorough manner.

Essentials of Industrial Health, by C. O. Sappington, M.D., (\$6.50. *J. B. Lippincott Co., Philadelphia*) is presented with the thought that the health of the worker is paramount to the continuity of production. This book helps the average physician to realize that industrial health goes beyond the ordinary practice of curative medicine. An excellent book.

Edward Tyson, M.D., R.F.S., by M. F. Ashley-Montagu (\$5.00. Vol. XX. *American Philosophical Society, Philadelphia*) is a study of the rise of human and comparative anatomy in England. Tyson was the first to call attention to the close relationship of man and ape. While he made many more contributions, what is of greater interest is the study in the book of the report of scientific development of the period.

Rehabilitation of the War Injured, A Symposium, edited by W. B. Doherty, M.D., and D. D. Runes, Ph.D., (\$10.00. *The Philosophical Library, Inc., New York City*) presents 670 pages packed with information about all phases of the subject.

Mary Carstens, M.D., by Mildred Foulke Meese, (\$2.00. *Bobbs-Merrill Co., Indianapolis*) takes Mary on through life, in a volume telling the story of her highschool days, her college days, her medical career, and now we find her the first woman interne in Victory Hospital. A good war-time story which will resolve some of the problems of you internes.

Prelude to Sanity, by S. Greene, (\$3.50. *Master Publications, Ft. Lauderdale, Fla.*) presents a book now and then which is rather ideological and has nothing structurally in common with the scientific or literary orientations of the day. This is such a book. It points out that society is an organism and troubles are not a generic phenomenon.

Gynecological and Obstetrical Urology, by Houston S. Everett, M. D., (\$6.00. *The Williams & Wilkins Co., Baltimore*) presents the subject especially as it has been developed for the gynecological staff at Johns Hopkins Medical School, brought up to the minute with chemotherapy.

American Medical Practice in the Perspectives of a Century, by Bernhard J. Stern, Ph.D., (\$1.50. *The Commonwealth Fund, New York City*) is a broad recitation of the social and economic world of today, revealing the effects which the growth of machine production, industrial urbanization, and economic concentration have had on the health of the people. Paralleling these, he outlines the problems of medical care. It is a book that every one of us should read.

Modern Clinical Syphilology, by John H. Stokes, M.D., Herman Beerman, M.D., and Norman R. Ingraham, Jr., M.D., and his associates, (\$10.00. 3rd Ed. *W. B. Saunders Co., Philadelphia*) marks the point where modern clinical syphilology attains its majority. The book belongs in every clinician's library.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

February, 1945

No. 2

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## Cirrhosis of the Liver

A. C. IVY, Ph.D., M.D.

IT is my desire to make this presentation as practical and logical as possible. It can not be a complete consideration of the subject. An excellent recent and very complete discussion of cirrhosis of the liver will be found in Litchman's "Diseases of the Liver".

### DEFINITION

Clinically, cirrhosis of the liver is a disease in which, during a period of months or several years, the hepatic parenchyma in the presence of more or less regenerative activity is slowly destroyed in association with the contraction of connective tissue, with or without the formation of new connective tissue, and which frequently terminates with the signs and symptoms of hepatic insufficiency and portal hypertension. Although the disease is frequently progressive, arrested cases occur.

Pathologically, cirrhosis of the liver is applied to any condition in which there is parenchymatous degeneration with either a real or an apparent increase in connective tissue without reference to whether the process was or was not progressive during life. Some students of the subject hold that the term cirrhosis should only be applied in those instances in which the increase in connective tissue is real. They would not include those "toxic cirrhotoses" (see I below) in which the increase in fibrous tissue is only apparent and due to the condensation of the stroma.

Some students of the subject recognize three general primary types: I, Primary Parenchymal Injury; II, Primary Mesenchymal Injury; and, III, Combined Mesenchymal and Parenchymal Injury.

Presented at the Second General Session, Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Columbus, May 2-4, 1944.

### The Author

● Dr. Ivy, Chicago, Ill., is a graduate of Rush Medical College, University of Chicago, 1922; member, American Gastro-Enterological Association, American College of Physicians, and the American Physiological Society, Chicago Institute of Medicine; and Nathan Smith Davis professor of physiology, Northwestern University Medical School, Chicago.

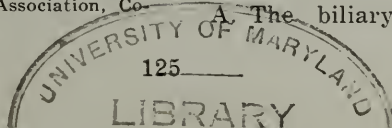
I. Cirrhosis Due to Primary Parenchymal Injury is best exemplified by the end stage of acute yellow atrophy of the liver due to acute intoxications caused by unknown agents and such agents as chloroform, phosphorus, mushroom, and perhaps cincophen (1 in 250,000 cases of administration).

Histologically the liver manifests a patchy destruction, shrunken lobules, and some areas which appear quite normal. Grossly the liver is small and the apparent increase in connective tissue is due chiefly to condensation of the stroma.

Clinically the course of the disease is rapid in its early stage and is characterized by intense jaundice and marked impairment of liver function. Later sufficient regeneration may occur to maintain life, or further condensation of connective tissue may produce terminal jaundice and ascites.

II. Cirrhosis Due to Primary Mesenchymal Injury is best exemplified by the two types of biliary cirrhosis, lues, bilharzia infestation, pigment cirrhosis, hemochromatosis, and Gaucher's disease.

A. The biliary cirrhosis which occurs sec-



ondary to extrahepatic mechanical obstruction of the bile duct due to stone, cancer or stricture is well known, but rather infrequently seen today because of early surgical intervention. Histologically in this condition the parenchyma degenerates and connective tissue spreads from the bile ducts to surround the lobules. Grossly the liver frequently becomes granular and nodular. Clinically the jaundice is marked and the liver is enlarged. The jaundice, unless the obstruction is relieved or is intermittent, persists, liver function is markedly impaired and cholemia frequently but not always ensues in several months. If the patient survives for a sufficient period, bouts of fever occur, the liver becomes smaller, and portal obstruction with ascites occasionally occurs terminally.

B. In the other type of biliary cirrhosis (Hanot's type) there is no obstruction of the extrahepatic bile ducts.

Histologically evidence of intrahepatic cholangitis is present with a pericholangitic increase in connective tissue with a widening of the portal areas. The lobular structure is maintained, except when the disease progresses and the distribution of connective tissue becomes multilobular; then it resembles portal cirrhosis, the third general type of cirrhosis.

Grossly the surface of the liver is finely granular, unless a multilobular distribution of connective tissue occurs.

Clinically the disease starts with the general symptoms of the "grippe". An olive green jaundice, usually with itching, occurs early with non-tender enlargement of the liver and spleen. As the disease continues, the jaundice varies in intensity, and bouts of fever occur intermittently. Clubbing of the fingers and toes usually occurs, and a hypertrophic osteoarthropathy may result. Secondary atrophy of the parenchyma results and the patient becomes drowsy and coma follows. Ascites and hematemesis occur late but only occasionally, probably because the connective tissue is arranged in longitudinal sheaths and does not compress the radicles of the portal veins. It occurs most frequently in young patients.

**III. Cirrhosis Due to Combined Mesenchymal and Parenchymal Injury** is the most common type, and is exemplified chiefly by (a) portal, Laennec's, or nodular cirrhosis, and (b) hypertrophic fat necrosis.

A. **Portal or Laennec's cirrhosis** is characterized by a diffuse sclerosis which markedly alters the architecture of the liver.

Histologically there is an increase in the connective tissue around and within the lobules. The growth of new connective tissue and regeneration of hepatic cells, which occurs each time after the cyclic episode of cellular ne-

crosis, is disorganized, so that adenomatous nodules are formed which do not adequately connect with the bile ducts and are not adequately supplied with blood. Hence, these adenomas become bile stained and are susceptible to injury.

Grossly the liver is nodular during the hypertrophic and atrophic stages of the disease. The disarrangement of the architecture of the liver predisposes to obstruction of the vascular and biliary channels, especially the former. Jaundice is not conspicuous, as in the other types of cirrhosis, throughout the disease, but ascites is quite common terminally. It should be emphasized that patients with portal cirrhosis may have the disease for a period of time and then suddenly "collapse"; that is, their liver may be "compensated", causing no jaundice or ascites, and then may become suddenly "decompensated".

B. In **hypertrophic fat cirrhosis**, histologically, there is a fatty degeneration of the parenchyma and a diffuse proliferation and infiltration of connective tissue. Clinically, in a few instances the liver may be enlarged; evidence of hepatic insufficiency occurs early by "liver function tests". After a variable period, jaundice, fever, cholemia and coma occur terminally. A fatty and enlarged liver not infrequently accompanies diabetes mellitus and disappears on good management.

#### ETIOLOGY

**Constitutional Factor.** When one exposes laboratory animals under controlled conditions to various agents or agencies which deleteriously affect the liver, a striking variation in susceptibility is observed both in regard to tolerance and the extent of sclerosis. The same is true of men exposed to toxic agents.<sup>42</sup> This variation in susceptibility can only be assumed to be due to unknown or constitutional factors.

**Experimental Production.** Experimentally cirrhosis of the liver can be produced in many ways.<sup>1,2</sup> These may be grouped under four general topics: (a) toxic agents; (b) infections; (c) metabolic disturbances; (d) obstruction of extrahepatic bile ducts. It has been found uniformly that a combination of agents or agencies is more effective than a single agent.

This means that in each case of suspected liver involvement a very careful history should be obtained in a search for toxic, infectious and metabolic factors and obstructions of the bile duct. I shall refer only to some of the metabolic factors since our knowledge regarding them is most recent and they bear on the problem of therapy.

A high fat diet by producing a fatty liver may in some instances cause a diffuse cirrhosis.<sup>3,4</sup> Diabetic dogs kept on an adequate diet with meat



and controlled with insulin frequently develop a diffuse cirrhosis.<sup>5</sup> Achylia pancreatica also predisposes to fatty liver.<sup>6,9</sup> This is significant because of the frequency of fibrous pancreatitis in biliary tract infections, alcoholism, and other intoxications. A low protein and high fat diet produces a fatty liver and a diffuse cirrhosis which is prevented by choline.<sup>10</sup> Deficiency of the Vitamin B-Complex certainly predisposes<sup>11,12</sup>. Excess cystine in the diet predisposes<sup>13,14</sup>; methionine antagonizes<sup>16</sup>, Vitamin C deficiency also produces or predisposes to cirrhosis.<sup>15</sup>

Alcohol alone has never produced cirrhosis experimentally. It has been found to augment the hepatic injury due to Vitamin B-Complex deficiency<sup>17</sup>, phosphorus, chloroform, carbontetrachloride, bacteria<sup>2</sup>, and a high fat and meat diet.<sup>18</sup> In the latter a fatty liver was produced by a high fat diet, and then four to seven days of alcohol and meat was alternated with high fat feeding without alcohol.

Many studies show that a diet high in carbohydrate, relatively high in protein without the extractives of meat and low in fat, high in vitamins especially the B-Complex and lecithin or choline, and methionine (a sulphur containing amino acid found in casein, egg albumin, meat) protects the liver from injury.<sup>19</sup> It should be recalled that meat extractive predisposes to "meat intoxication" in Eck fistula dogs and predisposes to ascites in biliary obstructive cirrhosis in dogs.<sup>20</sup>

#### DIFFERENTIAL DIAGNOSIS

The differential diagnosis of the types of cirrhosis frequently constitutes one of the most difficult diagnostic problems in medicine. An exploratory laparotomy and a biopsy or an autopsy is the only way an absolute diagnosis can be made. To diagnose the presence of cirrhosis in the compensated stage is frequently difficult and beset with error. And, it is sometimes not an easy task, solely on the basis of symptoms, signs and laboratory findings, to diagnose decompensated cirrhosis.

The differential involves a consideration of the many causes (a) of dyspeptic symptoms such as flatulent indigestion; anorexia, nausea, vomiting, abdominal distress, diarrhoea and constipation, (b) ascites, (c) jaundice, (d) abdominal pain, (e) weight loss, (f) hematemesis, (g) enlarged liver and spleen, (h) edema of the legs, (i) pruritis, (j) macrocytosis of erythrocytes. No group of symptoms and signs is specifically characteristic of the disease. But, a thorough history and physical examination and clinical experience in the interpretation of the history and physical findings assist greatly.

Patients with portal cirrhosis have relatively little hair and spider nevi are most commonly observed in this disease.

Ascites and jaundice are the most prominent

signs of the "decompensated" stage of the disease. But, they occur together at some time during the course of the disease in only about 50 per cent of the cases of portal or diffuse cirrhosis. And, cirrhosis is the cause of only from 5 to 7 per cent of the cases of jaundice and of only 10 per cent of the cases of ascites. However, if one rules out ascites due to cardiac weakness, nephritis, peritoneal disease and other readily diagnosed causes, about 85 per cent of the remaining cases of ascites are due to cirrhosis.<sup>2,21,22,23</sup> Jaundice can not be similarly reduced statistically. Though jaundice occurs quite consistently in subacute liver atrophy (toxic cirrhosis), very frequently in cases of biliary cirrhosis and less frequently in portal cirrhosis, portal cirrhosis is more frequent than the other two types by about 8.5 to 1.<sup>22</sup> Considering portal cirrhosis alone, ascites occurred in 78 per cent and jaundice in 65 per cent of the Ratnoff-Patek series of 386 patients.<sup>12</sup>

**Dyspeptic Symptoms.** These along with weight loss are the earliest and most frequent symptoms of portal cirrhosis.<sup>12,24</sup> This would indicate that such patients should have their hepatic reserve measured by two or more of the tests used for that purpose.<sup>25</sup> If this were done, decreased liver function would probably be detected in the early course of the disease and the course of the disease arrested or retarded.

**Abdominal Pain.** Non-colicky pain (rt. hypochondrium) occurs during the course of the disease in from 10 to 45 per cent of cases, according to different authors; colicky pain is rare. Ninety-six per cent of jaundice patients with stones complain of colicky pain. In carcinomatous jaundice 25 per cent complain of colicky and 35 per cent of dull pain.<sup>2</sup> Only 25 per cent of patients with medical jaundice complain of dull pain,<sup>2</sup> and colicky pain is rare, except in the presence of stones in hemolytic icterus which is a surgical condition.

**Hematemesis.** This sign occurs in about 25 per cent of patients with portal cirrhosis, and rarely in patients with biliary cirrhosis and subacute atrophy. It should be kept in mind that patients with hepatic disorders may develop a "peptic ulcer." Cirrhosis ranks next to "peptic ulcer" as a cause of hematemesis.

**Enlarged Liver and Spleen.** The liver is palpable and not tender in about 75 per cent and the spleen in about 45 per cent of patients with portal cirrhosis. When the liver is not enlarged and nodular, most of the antemortem diagnoses of portal cirrhosis are made after laparotomy. In the non-obstructive type of biliary cirrhosis (Hanot), the liver and spleen are decidedly enlarged; in the obstructive type, the liver and not the spleen is usually enlarged. There are many other causes of hepatomegaly and splenomegaly, however.

**Pruritis.** This symptom occurs in less than 5

per cent of patients with portal cirrhosis. Itching is frequent and persistent in both types of biliary cirrhosis, as in jaundice due to obstruction of the bile duct (50 per cent of cases), catarrhal jaundice, hepatitis, but not hemolytic jaundice. In hepatitis, itching may disappear with or shortly after the onset of jaundice.<sup>2,12</sup>

**Macrocytosis of Erythrocytes.** In some series, as many as 50 per cent of patients with cirrhosis manifest a macrocytic anemia,<sup>26</sup> due probably either to poor absorption of the erythrocytic maturation factor or to hepatic insufficiency. The macrocytes are frequently hypochromic ("target cells").

**Biliary vs. Portal Cirrhosis.** Clinically, biliary cirrhosis is characterized by a prolonged, more or less intermittent, jaundice, bouts of fever, itching, and clubbing of the fingers; dilated veins are relatively uncommon; the spleen is usually enlarged. In portal cirrhosis, jaundice, ascites, and hemorrhage may occur initially and terminally without a prolonged preceding jaundice; dilated veins are relatively common (26 per cent of cases), but clubbing of the fingers is rare.

#### THE DIFFERENTIAL DIAGNOSIS FROM A THERAPEUTIC VIEWPOINT

**I. Cirrhosis only with Jaundice.** Given a patient with jaundice, it is necessary to determine as soon as possible whether the jaundice should be treated surgically or medically. If it is a surgical jaundice, the sooner the patient is prepared for operation and operated the better. If it is a medical case, the medical treatment is essentially the same for all cases of hepatic insufficiency whether it be due to cirrhosis or some other cause, except for hemolytic, infectious, and certain other types of jaundice when attention to certain additional types of therapy is indicated. In my opinion, all cases of jaundice should be hospitalized for thorough study and diagnosis.

In the differential diagnosis of medical and surgical jaundice it is very important to:

1. Test of the Patency of the Ducts. (a) Color of the stools should be followed daily, but is unreliable because fat and certain foods mask the color of bile pigment. (b) Urobilinogen in the stools should be examined at frequent intervals. A quantitative test, if possible, should be used. (c) Duodenal drainage will yield bile in cirrhosis unless there is a high grade acute hepatitis or mechanical obstruction.

In stone, stricture or tumor, the ducts may be partially patent. This is more true of stone and stricture than of tumor (see Table I). It is important to remember that in adults, about 65 per cent of the cases of jaundice is due to a mechanical obstruction of some sort.

2. Test the Hepatic Reserve.

A. For differentiation. (a) Urobilinogen in the urine should be determined repeatedly. If bile

pigment is reaching the intestine and the liver is damaged, urobilinogen will be in excess in the urine with but few exceptions. If bile pigment is reaching the intestine in normal or less than

TABLE I  
Per Cent Frequency of Patent and Non-Patent Ducts<sup>24</sup>

| Obstruction     | 71 cases of stone | 20 cases of stricture | 26 cases of Ca of Pancreas | 13 cases of Ca of G.B. |
|-----------------|-------------------|-----------------------|----------------------------|------------------------|
| Partial . . . . | 87                | 70                    | 15                         | 20                     |
| Complete . . .  | 13                | 30                    | 85                         | 80                     |

normal amounts and the liver is not damaged, traces only of urobilinogen will be found in the urine. (b) Galactose tolerance, if done in the first week after appearance of jaundice, is valuable for differentiating between mechanical and hepatic jaundice. In mechanical jaundice, the liver is still able to handle galactose; in hepatic it is not able.

B. For determining the extent of hepatic damage. (a) The Prothrombin time or level of the blood should be determined. It will give an idea of the extent of hepatic damage; and, if abnormal and no or little response is obtained to Vitamin K, the extent of liver damage is grave. (b) The Hippuric acid test may be used to measure the hepatic reserve. (c) The blood protein level should be determined because if it is low the patient will be a greater operative risk and, if cirrhosis is present, will be predisposed to ascites.

3. Pain. If the patient has colicky pain it is important to remember that 96 per cent of patients with stones and 25 per cent with cancer complain of colicky pain and 35 per cent with cancer complain of dull pain.

4. X-ray Examination. (a) A cholecystogram will show little or no visualization in jaundice, or in rather extensive damage of the liver without jaundice, because the dye is not well excreted in the bile. It is a misleading test in jaundice or cirrhosis. However, X-ray opaque stones may be found. (b) An X-ray examination of the alimentary tract may reveal the cause of an enlarged liver with jaundice by showing the origin of a primary cancer in the stomach, colon or pancreas (deformity of the duodenum) or some other cause, or the presence of dilated veins in the esophagus.

5. Palpable Gall Bladder. Courvoisier's Law is of value. In the absence of a chronic cholecystitis (a thick-walled gall bladder), an obstruction of the common duct causes enlargement of the gall bladder.

6. The Secretin-Test of pancreatic function will indicate the presence of a degenerative process in the pancreas and assist in a suspected case of carcinoma or fibrosis of the pancreas. This can be done at the same time as the duodenal drainage to obtain evidence of patency of the ducts.



### 7. See cirrhosis with ascites below.

*Note:* (a) If the patient is having or has recently had colicky pain referable to the bile tract, and in the absence of a coronary infarct, I should operate after adequate preparation of the patient and the determination of the hepatic reserve. (b) In the absence of gall bladder colic, of a history of gall stones and bile tract surgery, of an enlarged gall bladder, of positive gastrointestinal X-ray findings, and in the presence of evidence that some bile is entering the intestine, it is appropriate to place the patient on "hepatic therapy" and observe for 2 to 6 weeks, since the majority of cases of intrahepatic jaundice subside in that period. (c) It must be remembered, however, that from 5 to 10 per cent of common duct stones are silent and that 85 per cent of common duct stones cause only partial obstruction and that the obstruction is complete in only 85 per cent of cases of obstruction due to cancer. But, if the patient's liver responds well to therapy no ground is lost in the case of silent stone, but ground is lost in some patients with pancreatic cancer. One has to balance the possibility of harming a patient with non-obstructive jaundice by an operation against the value of an earlier operation in 15 per cent of the cases of carcinoma of the pancreas and the possibility that a stone may be present. (d) If a primary cancer is found in the alimentary tract and the icteric index is 4 plus, there is little use in exploring, except perhaps to relieve pruritis in some cases by a cholecystogastrostomy.

**II. Cirrhosis with Ascites Only.** As far as I have been able to find, we still have to rely on the data collected by R. Cabot<sup>21</sup> for the relative frequency of the causes of ascites; and it is best to rely on autopsy data. A study of his 224 autopsy cases shows that if one rules out the more readily diagnosed causes of ascites (cardiac and renal involvement, tuberculosis, eclampsia, intestinal obstruction, uterine fibroids, ovarian cyst, acute yellow atrophy, etc.) cirrhosis is the cause in about 33 per cent and neoplastic disease in about 58 per cent of the remaining cases, thrombosis of the abdominal veins constituting a smaller group.

1. Examination of the abdomen. (a) To detect small amounts of fluid, the patient should stand, lean forward and a rectal examination for fluid ballotement in the pouch of Douglas made. Or, the abdomen should be percussed with the patient on his hands and knees. I mention this because it is done so infrequently. (b) Examination for palpable tumors.

2. Examination of the blood for evidence of leukemia, leucopenia, leucocytosis, etc.

3. Examination of the ascitic fluid.

4. Examine for evidence of portal hypertension. (a) Dilated superficial veins by inspection or infra-red photography. (b) Protoscopic examina-

tion (hemorrhoids are too non-specific). (c) Roentgenographic (moth eaten appearance at site involved) and esophagoscopy examination by an expert. (d) Water absorption and excretion test, if heart, blood protein level, and kidneys are normal. (Patient is given 1000 cc. of water or diluted tea on an empty stomach in 10 to 30 minutes. In 4 hours the excretion of less than 600 cc. of urine indicate poor absorption; a normal person usually excretes 1000 cc. This test is not specific for cirrhosis, however.)

5. Examine the hepatic reserve. (a) Blood protein level. (b) Prothrombin level. (c) Quantitative serum bilirubin or icteric index. (d) Bromsulphthalein elimination (5 mg. test). (e) Sugar tolerance-blood sugar to detect if diabetic type of curve is present. (f) Hippuric acid test.

**III. Cirrhosis without Ascites and Jaundice.** It is important for the patient, when possible, to detect cirrhosis before it becomes decompensated or before ascites, jaundice, or marked hepatic insufficiency occurs. Present knowledge of how to protect the liver and facilitate regeneration is worth applying early in the course of the disease to arrest it or to prolong life.

As indicated above the earliest and most frequent symptoms of cirrhosis are dyspeptic in nature. Thus, all patients with dyspeptic symptoms should have their hepatic reserve examined and should be tested for evidence of portal hypertension, it being kept in mind that hepatic reserve may be slightly decreased in cardiac disease, hyperthyroidism, nephritis, and certain infections and disease of the gastrointestinal tract.

1. Thorough examination of the alimentary tract with the X-ray and examination of the stools for fat and nitrogen loss, parasites, etc.

2. Cholecystogram. It should always be remembered that in the presence of hepatic insufficiency the dye may not be eliminated well and no or only a poor shadow will result. In the experience of Snell,<sup>24,27</sup> "it is remarkable how frequently the diagnosis of cholelithiasis has been made in cases of cirrhosis." Other diseases in which cirrhosis is most frequently found at operation are cholecystitis, duodenal ulcer, and Banti's disease (primary splenomegaly with secondary hepatic enlargement and tertiary shrinkage of the liver with ascites).

3. Examination of the genito-urinary tract, disease of which not infrequently causes dyspeptic symptoms.

4. Test of hepatic reserve. (a) Quantitative serum bilirubin, or icteric index, when other causes of yellow serum have been ruled out. Hyperbilirubinemia is frequent in compensated cases of cirrhosis. (b) Galactose tolerance, hippuric acid, and bromsulphthalein (5 mg.) clearance. (c) It is also advisable to estimate the prothrombin and blood protein levels, since these

may be low occasionally even when the bilirubin is not strikingly elevated.

5. Blood cell and hemoglobin study. Macrocytosis, anemia, leucopenia or leukemia may be found.

6. Examine for evidence of portal hypertension (*vide supra*).

It is well to remember that in certain cases of portal cirrhosis dilation of the collateral blood supply of the liver does not occur, and that in some cases dilation may be found with no history of ascites. This latter condition may be due to a failure of the blood protein level to fall. The development of adequate collateral circulation with normal blood protein level may relieve ascites.<sup>2</sup>

It should be reiterated that when cirrhosis is suspected the extent of the body hair and the presence of spider nevi should be considered.

#### PROGNOSIS

In Hanot's type of biliary cirrhosis the average length of life is about 5 years after the onset of the disease, though some patients have survived as long as 10 to 15 years. With benign obstructive biliary cirrhosis the average survival after the onset of surgically untreated jaundice is about 4 years, with malignant about 0.5 year. cirrhosis the average survival after the onset of symptoms is about 2 years and after ascites is 1 year. Patients with compensated portal cirrhosis may live longer.

Petak<sup>28</sup> and Fleming and Snell<sup>29</sup> have observed frequent recovery from ascites after instituting a relatively high protein and Vitamin B diet, and 45 per cent of 53 cases treated by Patek<sup>28</sup> survived for 2 years after the onset of ascites.

#### TREATMENT

**General:** Sources of the cause of cirrhosis should be carefully looked for in the patient's environment and if found eliminated. It is believed to be advisable to eliminate alcohol, and smoking, to reduce condiments and the administration of drugs which potentially irritate the liver (phenol compounds, salicylates, nembutal, arsenicals, mercurials, exposure to volatile irritants, cinchophen, atabrine, etc.) to a minimum, or to eliminate them when possible.

Patients with "catarrhal jaundice" should have complete bed rest, as in an acute or subacute hepatic degenerative condition, and isolated from persons with "colds." This is for prophylactic purposes. Workers exposed to the fumes of volatile hepatotoxic substances or persons habituated to alcohol should be given the "protective diet" below.

**Diet.** Patients whose liver has been insulted or is subject to insult as well as those with cirrhosis should receive a diet high in carbohydrate, relatively high in protein and low in fat,

and with plenty of Vitamin B-Complex, Vitamins A (10,000), D (10,000 units), and C (100-150 mg.). For example; carbohydrate, 500 gm.; protein 140 gm.; fat, 60 gm. I believe that only small amounts of meat should be permitted, unless the meat is boiled and the extractives discarded, unless the hepatic reserve is adequate to care for the meat extractives. In addition, I should recommend the administration of 25 gm. of dried brewer's yeast daily. In acute or subacute involvements, especially if intestinal absorption is affected or if neuritis is present, the administration of 5-20 mg. of thiamine, 10-40 mg. of riboflavin and 50-200 patients will require Vitamin K parenterally. (Some patients become sensitive to large doses of thiamine given intravenously.)

The diet, if the patient can consume the quantity of food indicated with the dried yeast, should be adequate, without giving soya bean lecithin, or choline to decrease fatty infiltration and degeneration. In acute toxic hepatitis the parenteral administration of methionine (sulfur containing amino acid) has been reported to yield rather spectacular results.<sup>30</sup>

I suggest that the food be thoroughly masticated, or fluid and soft, to avoid irritation or injury to the esophageal mucosa.

**Insulin.** If the patient has a pancreatic fibrosis or insufficiency of insulin, then insulin should be given. This will be manifested by a frankly diabetic blood sugar curve (not a blood sugar curve due to hepatic insufficiency) or by a glycosuria when on the high carbohydrate diet. A number of patients with portal cirrhosis have not compensated until insulin was given.<sup>31,32</sup> It is still mooted, whether patients with acute hepatitis should receive insulin, since most of the experimental evidence is to the contrary; but the blood sugar level should be kept high in such patients.<sup>19</sup>

**Liver Extract.** This is usually high in Vitamin B-Complex, especially in the case of the cruder preparations. It should be used in the presence of macrocytosis. Very favorable results in cirrhosis with ascites and even hepatic coma have been reported when it has been given daily for one week and then once or twice weekly.<sup>2</sup>

**Blood Plasma.** In anemia; especially with a low blood protein level, a whole fresh blood transfusion is indicated. When there is no anemia but the blood protein level is low, plasma can be used; it is especially indicated early in those cases in which due to poor digestion and absorption or poor hepatic reserve the blood protein level can not be elevated or is difficult to elevate with a diet.

On the basis of present evidence, intravenous protein digest or amino acid feeding can not be recommended in the place of plasma or whole blood, though such therapy has been used with apparent benefit in hepatitis<sup>33,35</sup> and in cirrhosis.<sup>35,36</sup> If it proves that such patients uni-



formly tolerate and are improved by such therapy it will be a valuable contribution. It should be remembered that patients who are forming ascitic fluids are losing much protein from their circulation and also their body when tapped.

**Diuretics and Purgatives.** I seriously question whether either should be used to counteract ascites if their use can be avoided, because I should suspect the former as being hepatotoxic, regardless of statements to the contrary, and the latter as upsetting an already disordered digestive tract. I should prefer paracentesis, in the recumbent position if the systolic blood pressure is low, to relieve abdominal distension. Bowel evacuations should, of course be well regulated; perhaps the best agents for this purpose, when required, are bile salts and heavy magnesium oxide.

**Bleeding Esophageal Varix.** Absolute quiet is indicated. I have seen one patient with a low prothrombin level apparently respond to Vitamin K intravenously, and unless such patients have been under careful observation they should receive such treatment. The favorable effect of other "hemostatics" is questionable. Westphal<sup>37</sup> has used local compression with an esophageal dilator for 24 to 48 hours with morphine and atropine. Ligation of the left gastric and left gastro-epiploic arteries with removal of the spleen may be advisable and has been performed in combination with blood transfusion. Injection of the varices with sclerosing agents has been tried.<sup>38</sup>

**Prophylactic Surgery for Portal Hypertension.** Henrikson<sup>39</sup> has reviewed the surgical methods and the results. The Talma-Morrison operation of omentopexy to decrease portal hypertension by increasing collateral circulation has been reported to yield favorable results in 65 per cent of the patients.<sup>39</sup> Ligation of the left gastric and left gastro-epiploic arteries with an omentopexy and removal of the spleen has been used, though except in Banti's disease the removal of the spleen may not be advisable.<sup>40</sup> More recently Moersch,<sup>41</sup> using the esophagoscope, has injected the varices with a sclerosing agent (sodium morrhuate).

All surgeons make a plea for the early recognition of portal hypertension, and point out that their results are most favorable when the operation is performed early and the patient is in good physical condition. It has yet to be demonstrated that surgical therapy yields better results than medical therapy.

#### SUMMARY

In view of the fact (a) that many cases of portal cirrhosis are not recognized until in the decompensated stage, (b) that, due to the increased consumption of alcohol, and the exposure of many persons to toxic substances in industry, longed periods, it is probable that the incidence and the necessity of using atabrine over pro-

of cirrhosis will increase, (c) that the evidence now indicates that we can retard the course of the disease and perhaps arrest it in its early phases, (d) that the surgical results in reducing portal hypertension are improved by an early operation, (e) that the earliest symptoms of the disease are frequently vaguely dyspeptic in character, I close by making a plea for the early diagnosis of portal cirrhosis by subjecting patients with dyspeptic symptoms to a more thorough examination during which the hepatic reserve and the evidences of portal hypertension are examined.

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# A Study of Headaches and Vertigo and Their Correlations To the Derangement of the Sexual Function

IRWIN MASON, M.D.

OF the complaints encountered among the men examined for the Armed Forces, at the induction station, headaches and vertigo stand out in the foreground. When we consider that the men examined at these stations are selected men, men who have been screened by their local Selective Service Boards and represent the "best material available", the figures presented in this paper will appear more impressive.

## DEFINITIONS

For the sake of this paper, headaches were considered as a subjective complaint only if they were sufficiently intense or frequent enough to produce disability, or if they were associated with vertigo. Periodic or migraine headaches are herein included. An occasional headache, not disabling, or unaccompanied by any other allied symptoms, such as syncope, was not considered in this series of study.

Vertigo was considered when it fulfilled the definition according to Shuster's article on vertigo, which I take the liberty of quoting. "Vertigo is a subjective sensation of disturbed consciousness. It may be manifested in the form of (1) giddiness, which is a mild degree of fainting with a momentary loss of one's balance; (2) a sense of rotation, e.g., a sense of objects rotating about a person or a person rotating about objects; and (3) pulsion, a veering of a person to one side or another. All the foregoing sensations appear in the form of attacks; they are not continuous or constant."<sup>1</sup>

By derangement of the sexual function we mean premature ejaculations, delayed ejaculations, loss of erection, impotence, or combinations of those mentioned above, or alternating in those disturbances. Included here also is homosexuality.

## THE LITERATURE

A great deal of literature has been written on the differential diagnosis of the probable different etiological factors giving rise to headache and vertigo.<sup>2,3,4</sup> A review of this literature discloses that (1) in general, the etiological factors of vertigo and headaches are either organic or psychologic and malingering; and (2) that

This study was made possible with the kind permission and cooperation of Major Calvin P. McLaughlin, senior medical officer of the Armed Forces Induction Station, Cleveland, Ohio, and has been released for publication by the Bureau of Public Relations, War Department, Washington. Submitted May, 1944.

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the differential diagnoses between the organic and the psychologic factors are that in the former the presence of a demonstrable organic or physical condition is necessary, and that in the latter, the absence of organic disease and the presence of evidence of emotional disturbances are necessary.<sup>5</sup>

In many cases where there are no evidences of any physical, chemical, or organic etiological factors, and where apparently no emotional disturbances can be elicited, one has a great deal of difficulty in determining whether the headaches and vertigo are organic, functional, or psychogenic. This is especially true in those having these two symptoms following head injury. Persons with such injuries are often suspected of malingering. A correct diagnosis here becomes very important when we consider the frequency of disability claims in industrial cases because of headaches and vertigo following head injuries.

Dr. N. Savitsky<sup>6</sup> attempted to solve this problem by finding that headaches due to organic changes are different from psychogenic, in that in the latter, the sensations are felt as sensations of tightness or constriction; are less paroxysmal; and closely related to changes of mood. Such a description on the part of the patient is very unreliable, inadequate, inconclusive, and open to criticism.

## DIFFERENTIATION

Considering the time consumed, the great amount of work involved, and expensive laboratory procedure necessary to make special studies of the different types of headaches and vertigo (all impossible at the induction stations or at an office), a more practical and simpler method becomes necessary in order to differentiate organic from functional headaches and vertigo.

In looking for such a practical procedure, the author made a study in order to obtain some correlated factors in the life histories of the



men examined and who complained of headache and vertigo. When these men described their sex lives, the information disclosed by them seemed to point in the right direction. A search in the literature on the possible correlationship between headaches and vertigo, and derangement of the sexual function, revealed very little.

Paul Schilder,<sup>7</sup> writing on psychogenic vertigo in his book, "Psychotherapy," says, "Dizziness

1. White men between the ages of 18 to 25, inclusive.
2. Colored men between the ages of 18 to 25, inclusive.
3. White men between the ages of 26 to 37, inclusive.
4. Colored men between the ages of 26 to 37, inclusive.

Table 1 is called a general table. It lists the

TABLE 1—A GENERAL TABLE

| Column No.                                                                                     | Group 1<br>White Men<br>18-25<br>Inclusive | Group 2<br>Colored Men<br>18-25<br>Inclusive | Group 3<br>White Men<br>26-37<br>Inclusive | Group 4<br>Colored Men<br>26-37<br>Inclusive |
|------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------|--------------------------------------------|----------------------------------------------|
| 1. Total number of men examined                                                                | 2145                                       | 441                                          | 3234                                       | 703                                          |
| 2. Number and Percentage of single men                                                         | 1221<br>56.8%                              | 329<br>74.6%                                 | 571<br>17.6%                               | 131<br>18.6%                                 |
| 3. Number and Percentage of married men                                                        | 924<br>43.2%                               | 112<br>25.4%                                 | 2663<br>82.4%                              | 572<br>81.4%                                 |
| 4. Number and Percentage of men with headache and vertigo only                                 | 318<br>14.8%                               | 76<br>17.2%                                  | 297<br>9.4%                                | 24<br>3.4%                                   |
| 5. Number and Percentage with headaches and vertigo associated with other psychogenic symptoms | 325<br>15.1%                               | 132<br>29.9%                                 | 880<br>27.1%                               | 225<br>32%                                   |
| 6. Number and Percentage with headaches and vertigo associated with organic disease            | 136<br>6.3%                                | 66<br>14.9%                                  | 385<br>11.9%                               | 144<br>20.4%                                 |
| 7. Number and Percentage who did not complain of headaches and vertigo                         | 1366<br>63.7%                              | 167<br>37.9%                                 | 1672<br>51.6%                              | 310<br>44.1%                                 |
| 8. Number and Percentage who had sexual derangement                                            | 689<br>32%                                 | 241<br>54.6%                                 | 1832<br>56.6%                              | 412<br>58.6%                                 |
| 9. Number and Percentage with Premature ejaculations                                           | 439<br>20%                                 | 160<br>35.8%                                 | 1189<br>36.7%                              | 279<br>39.6%                                 |
| 10. Number and Percentage with impotence                                                       | 144<br>6.7%                                | 46<br>10.4%                                  | 312<br>9.6%                                | 81<br>11.5%                                  |
| 11. Number and Percentage with alternating sexual precox and impotence                         | 57<br>2.2%                                 | 16<br>3.6%                                   | 190<br>5.8%                                | 50<br>7.1%                                   |
| 12. Number and Percentage with homosexual practices                                            | 59<br>2.7%                                 | 19<br>4.3%                                   | 141<br>4.3%                                | 39<br>5.5%                                   |
| 13. Number and Percentage without any sexual experiences                                       | 241<br>11.2%                               | 49<br>11.1%                                  | 97<br>3%                                   | 11<br>1.5%                                   |

is the psychological sign of a sensual or moral disorientation in the world." If by sensual disorientation he means derangement of the sexual function, Schilder recognized their coexistence. To what extent they coexist, he did not say. This paper will tend to show to what extent derangement of the sexual function is present in the psychogenic and the organic headaches and vertigo.

A series of 6,523 consecutive men, both white and colored, from the ages of 18 to 37 is presented here. The examination of this series of men stretched over a period of 7 months. All men had complete physical examinations by the time they reached the author's station, the neuropsychiatric, which is the last station in the examination line. Everyone who complained of headaches and vertigo was given a complete neurological examination including eye ground studies.

A number of tables are presented here to show the different correlations. All tables have been divided into 4 groups.

number of men examined in each group, with different headings for the type of information sought in a specific numbered column. The figures are given for each group.

A study of these figures reveals that (1) pure headaches and vertigo are much more common in the younger groups, both white and colored (14.8 per cent and 17.2 per cent respectively), and are much less common among the older groups (9.4 per cent and 3.4 per cent for whites and colored respectively); (2) that there is a marked increase in the percentage of the older groups having multiple symptoms in comparison with that of the men in the same groups having pure headache and vertigo; (3) that this increase mentioned above is even more pronounced among the colored groups, as seen by making a comparison of the following figures and ratios. In the older white groups the increase is from 9.4 per cent of pure headaches and vertigo to 27 per cent of men with multiple symptoms, an increase of 2.8 times; while in the same age groups among the colored, the increase is from

3.4 per cent to 32 percent, an increase of 9.4 times.

#### CONCLUSION SO FAR

The conclusions one may draw from these figures is that the older the person the more conflicts he has to overcome, and the less sure he is of himself, and, therefore, the headaches and vertigo are more apt to be associated with other psychogenic symptoms, such as syncope, hypertension, tachycardia, etc. One may also deduct that the colored person feels even much more insecure than the white person, has many more conflicts, and, therefore, the number of pure headaches and vertigo is much smaller, and the number with multiple psychogenic symptoms much greater as he gets older.

Column 6 gives the number and percentages of men who had headaches and vertigo associated with organic disease. The meaning of associated organic disease will be discussed subsequently when we reach Table 4. The figures tend to show that with the increase in age, there is also an increase in associated organic diseases, and the proportional increase of the colored compared to the whites is even greater, almost 2 to 1.

Columns 8, 9, 10, 11, 12, and 13 reveal very interesting figures. First, disturbances of the sexual function, which I choose to call derangement of the sexual function, is much more prevalent than is commonly believed. With the exception of the younger white group, showing 32 per cent of the men having derangement of the sexual function, 50 per cent of the rest of the series have derangement of the sexual function. Second, the most common form of derangement of the sexual function is premature ejaculations. Third, in the homosexual practices we see an increase among the older groups, and the increase is more marked among the colored as compared to the white groups. Fourth, among the younger groups who had no sexual experiences the percentages are the same for the colored and whites, about 11 per cent; while in the older groups, 3 per cent of the whites had no sexual experience, and only 1.5 per cent of the colored.

The large majority of those men having derangement of the sexual function recognized the disturbances as abnormal and unsatisfactory. Some among the group having premature ejaculations considered this form of sexual derangement as a sure sign of "virile manhood". Others saw nothing abnormal about their premature ejaculations and blamed their wives as being frigid, although the ejaculations came within two minutes after the start of coitus. All men having the other sexual disturbances considered them to be abnormal.

Breaking down Table 1 into the several components we can present the subsequent tables for the study of the correlation between the

various types of headaches and vertigo with the disturbance of the sexual function.

TABLE 2

The Number and Percentage of Men Who Have Derangement of the Sexual Functions Found Among the Series With Headaches and Vertigo Only

| Number of Men | Age Group | White or Colored | Number and Percentage Having Derangement of Sexual Function |
|---------------|-----------|------------------|-------------------------------------------------------------|
| 318           | 18-25     | White            | 251 or 79%                                                  |
| 76            | 18-25     | Colored          | 62 or 81.6%                                                 |
| 297           | 26-37     | White            | 249 or 83.3%                                                |
| 24            | 26-37     | Colored          | 22 or 91.6%                                                 |

In Column 4 of Table 1 we see the number of men examined who complained of vertigo and headaches. These men had no other symptoms that could be elicited and had no associated organic diseases. These men were asked if they had any sexual difficulties as listed in Columns 9,

TABLE 3

The Incidence and Percentage of Men Having Severe Headaches and Vertigo (with Associated Psychogenic Symptoms) Who Have Derangement of the Sexual Function

| Number of men having severe headaches and vertigo | Age Group | Colored or White | Number and Percentage Having Disturbances of Sexual Function |
|---------------------------------------------------|-----------|------------------|--------------------------------------------------------------|
| 325                                               | 18-25     | White            | 305 or 94%                                                   |
| 132                                               | 18-25     | Colored          | 128 or 96.9%                                                 |
| 880                                               | 26-37     | White            | 853 or 96.6%                                                 |
| 225                                               | 26-37     | Colored          | 221 or 98.2%                                                 |

10, 11, and 12 of Table 1. The number and percentage of men that usually or continuously had derangement of the sexual function is listed in the extreme right column of Table 2. A comparison of the percentages of the men who complained of headaches and vertigo only who had derangement of the sexual function with those in column 8, shows a great increase in the incidence of sexual disturbances in the former series in contrast with the incidence of the entire series of men examined, thus ranging from 79 per cent in the younger white group to 91.6 per cent for the older colored group, as against 32 per cent and 58 per cent.

This increase in the incidence of derangement of the sexual function becomes even more apparent when we study Table 3, listing the men who had in addition to headaches and vertigo, other associated psychogenic symptoms.

In order to better explain what is meant by associated psychogenic symptoms Table 3A is inserted.

The men in this table (3A) had no demonstrable organic disease. Although hypertension and tachycardia are included in this list, these two symptoms are not considered organic, because these men were found to have a pulse of less than 100 and blood pressure less than 150/90 after rest. Alcoholism is considered here as a psychogenic symptom. Those showing alcoholic polyneuritis are not included. This table also



TABLE 3A  
The Number and Percentages of Men Who Complained of Headache and Vertigo and Who Also Had One or More of Associated Psychogenic Symptoms

| With One or More of These Associated Psychogenic Symptoms | Group 1<br>White<br>Age 18-25 | Group 2<br>Colored<br>Age 18-25 | Group 3<br>White<br>Age 26-37 | Group 4<br>Colored<br>Age 26-37 |
|-----------------------------------------------------------|-------------------------------|---------------------------------|-------------------------------|---------------------------------|
| With transient tachycardia and/or hypertension            | 98<br>12.5%                   | 23<br>8.3%                      | 177<br>11.3%                  | 40<br>10.1%                     |
| With Enuresis                                             | 46<br>5.9%                    | 56<br>20.4%                     | 208<br>13.3%                  | 86<br>22%                       |
| With Alcoholism                                           | 11<br>1.4%                    | 13<br>4.7%                      | 56<br>3.5%                    | 16<br>4%                        |
| With Syncope                                              | 92<br>11.4%                   | 23<br>8.3%                      | 309<br>19.8%                  | 69<br>17.5%                     |
| With Somnambulism                                         | 61<br>7.6%                    | 13<br>4.7%                      | 109<br>6.9%                   | 14<br>3.5%                      |
| With Stuttering                                           | 17<br>2%                      | 24<br>1.5%                      | 1<br>1.3%                     | 0<br>0                          |
| Total Number with additional symptoms                     | 325<br>41.7%                  | 132<br>48.1%                    | 880<br>56.3%                  | 225<br>57%                      |
| Total Number examined with Headache and Vertigo           | 779                           | 274                             | 1562                          | 393                             |

shows (1) that the most common psychogenic symptoms associated with headaches and vertigo are hypertension and tachycardia, enuresis, syncope, and somnambulism; and (2) that enuresis is more common among the colored than the whites. The men having these symptoms with headaches and vertigo were considered as severe.

The derangement of the sexual function among these men is as seen from this table almost universal. The percentages go up as high as 94 per cent in the young whites to 98.2 per cent in the older colored.

A comparison of the percentages of men having derangement of the sexual function found in Tables 2 and 3 with those in Tables 4 and 5 will bring out more clearly the very purpose of this paper, viz., that there is a definite correlation-ship between headaches and vertigo and derange-ment of the sexual function. Thus, in Table 4, taken from Column 6 in Table 1, consisting of men who complained of headaches and vertigo, associated with organic diseases, the percentage of those having derangement of the sexual func-tion range from 16.3 per cent for the young whites to 31.2 per cent for the older colored group.

ORGANIC DISEASE

Breaking down the various types of organic diseases found among the men in Table 4, and forming another Table 4A, we find that derange-ment of the sexual function is more common among those who had peptic ulcers. These ulcers were considered organic because they were veri-fied by X-ray evidence. Ulcers belonging to the group of psychosomatic diseases, may easily ac-count for this increase in sexual disturbances.

Central nervous system lues, being more com-mon among the colored, also tends to increase the incidence of the derangement of sexual function from an organic point of view, espec-

ally impotence. But in spite of the above men-tioned two diseases, the percentage does not

TABLE 4  
The Number and Percentages of Men Who Complained of Headaches and Vertigo, Associated With Organic Diseases (See Table 4A below), Who Had Derangement of the Sexual Function

| Number of Men | Age Group | Colored or White | Number and Percentage of Sexual Derangement |
|---------------|-----------|------------------|---------------------------------------------|
| 136           | 18-25     | White            | 22 or 16.3%                                 |
| 66            | 18-25     | Colored          | 14 or 21.2%                                 |
| 385           | 26-37     | White            | 92 or 23.8%                                 |
| 144           | 26-37     | Colored          | 45 or 31.2%                                 |

reach the proportion of those found in the non-organic headaches and vertigo, and certainly not of those found in the severe psychogenic head-aches and vertigo.

The number and percentages of men with headaches and vertigo associated with one or more of these organic symptoms; the number and percentages of men having sexual derange-ment for each associated disease.

If two or more organic diseases co-existed in the same individual, the one chosen was the one most complained of by the selectee, or the one most disabling, or the one he was most aware of.

The percentage figures among the men hav-ing headaches and vertigo with organic disease who display derangement of the sexual function are not very different from those found among men who did not complain of headaches and vertigo and had sexual disturbances. For com-parison Table 5 is inserted below.

DISCUSSION

A lengthy discussion of the possible theories and explanations for the seemingly obvious and definite correlation-ship between psychogenic headaches and vertigo with the derangement of the sexual function will not be attempted here. Briefly, however, this correlation-ship may be ex-

TABLE 4A

|                                                              | Group 1<br>White Men<br>18-25 |             | Group 2<br>Colored Men<br>18-25 |             | Group 3<br>White Men<br>26-37 |             | Group 4<br>Colored Men<br>26-37 |             |
|--------------------------------------------------------------|-------------------------------|-------------|---------------------------------|-------------|-------------------------------|-------------|---------------------------------|-------------|
|                                                              | No. &<br>%                    | Sex<br>Der. | No. &<br>%                      | Sex<br>Der. | No. &<br>%                    | Sex<br>Der. | No. &<br>%                      | Sex<br>Der. |
| Total Number of Men complaining of Headaches and Vertigo     | 779                           |             | 274                             |             | 1562                          |             | 393                             |             |
| Men with Headaches and Vertigo associated with head injuries | 76<br>9.7%                    | 13<br>17%   | 31<br>11.3%                     | 6<br>19.3%  | 251<br>16%                    | 56<br>22.3% | 81<br>20.5%                     | 26<br>32.1% |
| With Epilepsy                                                | 2<br>.2%                      | 0<br>0      | 0<br>0                          | 0<br>0      | 6<br>.3%                      | 1<br>16.6%  | 1<br>.2%                        | 0<br>0      |
| With Heart Disease                                           | 11<br>1.4%                    | 2<br>18%    | 4<br>1.4%                       | 0<br>0      | 17<br>1%                      | 3<br>17.6%  | 2<br>.5%                        | 1<br>50%    |
| With Diabetes                                                | 0<br>0                        | 0<br>0      | 0<br>0                          | 0<br>0      | 4<br>.2%                      | 0<br>0      | 0<br>0                          | 0<br>0      |
| With Peptic Ulcer                                            | 6<br>.7%                      | 5<br>83.3%  | 2<br>.8%                        | 1<br>50%    | 19<br>1.2%                    | 15<br>79%   | 2<br>.5%                        | 1<br>50%    |
| With Otitis Media                                            | 21<br>2.7%                    | 0<br>0      | 9<br>3.2%                       | 2<br>22.2%  | 31<br>2%                      | 6<br>19.3%  | 10<br>2.5%                      | 2<br>20%    |
| With Sinusitis                                               | 17<br>2.1%                    | 2<br>11.7%  | 4<br>1.4%                       | 0<br>0      | 41<br>2.6%                    | 7<br>17%    | 15<br>3.8%                      | 3<br>36.3%  |
| With C. N. S. Lues                                           | 3<br>.3%                      | 0<br>0      | 16<br>5.8%                      | 5<br>31.2%  | 16<br>1%                      | 4<br>25%    | 33<br>8.5%                      | 12<br>36.3% |
| Total Number with Organic Disease                            | 136<br>17.4%                  | 22<br>16.3% | 66<br>24%                       | 14<br>21.2% | 385<br>24.3%                  | 92<br>23.8% | 144<br>36.6%                    | 45<br>31.2% |

plained in two general ways, depending upon which school of psychiatric thought one follows:

(1) The derangement of the sexual function is the cause of the psychoneurotic symptoms, and the same holds true of psychogenic head-

TABLE 5

The Number of Men Who Did Not Complain of Headaches and Vertigo and Had Disturbances of Sexual Functions

| Number of men examined | Age Group | Colored or White | Number and Percentage having sexual derangement |
|------------------------|-----------|------------------|-------------------------------------------------|
| 1366                   | 18-25     | White            | 111 or 8.1%                                     |
| 167                    | 18-25     | Colored          | 37 or 22.1%                                     |
| 1672                   | 26-37     | White            | 638 or 38.1%                                    |
| 310                    | 26-37     | Colored          | 124 or 40%                                      |

aches and vertigo. This explanation is open to question because, as seen in Table 5 where a study is made of the men who had no complaints of headaches and vertigo, and for that matter, had no complaints at all, the percentages of these men having sexual derangement run from 8.1 per cent in the young whites to 40 per cent in the older colored group. On the other hand, a number of men that complained of headaches and vertigo had no sexual experience.

(2) In psychoneurosis, no matter what the genesis may be, sexual derangement is a very common symptom and quite naturally will be found very often to be associated with other psychoneurotic symptoms such as psychogenic headaches and vertigo; and the more psychogenic symptoms one has the more likelihood that he will also have a disturbance of the sexual function. In other words, derangement of the sexual function itself is a psychoneurotic symptom.

The author, for one, fully agrees with this concept rather than the one stated under (1). This concept offers an explanation why so many men who did not complain of headaches and

vertigo had derangement of the sexual function. This disturbance of the sexual function in these cases is merely an isolated symptom of psychoneurosis. It also explains why, in many men who complain of headaches and vertigo associated with organic disease, we find derangement of the sexual function, because even in organic diseases psychogenic factors are superimposed to create emotional conflicts thus resulting in sexual derangement as a manifestation of the emotional disturbances.

#### CONCLUSIONS

1. Derangement of sexual function is very common among the population. The percentage runs almost the same as those given for the incidence of psychoneurosis.

2. Premature ejaculation is the most common form of derangement of the sexual function.

3. Sexual derangement is extremely common among men having psychogenic headaches and vertigo, and is almost universal among men having severe headaches and vertigo with associated symptoms.

4. The most common associated psychogenic symptoms of headaches and vertigo are tachycardia and hypertension, syncope, enuresis, and somnambulism.

5. In headaches and vertigo from organic disease, sexual derangement is much less common.

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# Diarrhea of Newborn. Report of Epidemic

FRANK MEOLA, M.D.

LATELY, reports of diarrhea of the newborn have become more common and this condition is more readily recognized. It may be accepted as an entity. Souther,<sup>1</sup> has called attention to its frequency in Ohio. Rice, et al.,<sup>2</sup> have made an extensive review of this disease entity.

About the middle of September, 1943, such an epidemic broke out in the nursery of one Akron hospital. This began following delivery of a woman who had diarrhea. The newborn infant developed diarrhea within 24 hours following birth. Soon a few other newborn in the nursery had diarrhea. In a short time the condition had spread to many others before its full significance was realized. Isolation of the known cases was attempted. This failed. A second approach to the problem was made by sending all newborn home immediately following birth. All known cases were sent to the Children's Hospital and turned over to the staff, thus assuring a complete change in personnel. Those infants that developed diarrhea at home were either treated there or brought to the Children's Hospital.

## MATERIAL

Of this epidemic 34 cases were observed and treated at the Children's Hospital. Though there were more cases than this, the others were treated in the home, or other hospitals. Table 1 shows that the majority of cases occurred in October. The epidemic gradually sub-

TABLE 1

| 1943  |      |      |      |      |       |
|-------|------|------|------|------|-------|
| Sept. | Oct. | Nov. | Dec. | Jan. | Total |
| 2     | 26   | 4    | 1    | 1    | 34    |

sided and an occasional case was seen by late December and January. This review consists of all those cases originally born at the hospital where the epidemic started, which developed diarrhea within the first month of life and

TABLE 2

| Number cases | Number Stool Cultures | Negative Stool Cultures | Case Fatality | Per Cent Case Fatality |
|--------------|-----------------------|-------------------------|---------------|------------------------|
| 34           | 26                    | 8                       | 8             | 23                     |

were observed and treated at the Children's Hospital. It does not represent the total number of cases in the epidemic.

## CHARACTER OF EPIDEMIC

The onset of diarrhea was usually sudden with foul liquid yellow stools. The stools were

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at times green and showed curds. All cultures failed to show any infectious or dominant organism in the stools. There was never any pus in the stools and only one case had light streaking of blood. The number of stools varied from 6 to 12 a day as noted by diaper changes, but usually, the number could more aptly be described as continuous.

Usually there was no initial fever and the usual course was afebrile. The physical examination as a rule was negative and no complications or associated pathology found. The severe cases and the remissions were characterized by apathy, circulatory collapse, dehydration, acidosis, and loss of weight. Vomiting was infrequent. The infant was usually hungry and would apply itself to the bottle ravenously unless too weak to do so. The diarrhea began anywhere from the first day to the first few weeks of life. The average day of onset was the seventh day of life.

The course of the disease was characterized by periods of regressions and remissions, usually short in duration. The regressions tended to give a false impression and tempted the physician to send the infant home.

## TREATMENT

Treatment followed the same lines for all even though the cases were under several different physicians. In brief, this consisted of restoring the fluid balance by normal sodium chloride, lactate Ringer's, glucose, and Hartman's solution. These fluids were given by subcutaneous or intravenous route. Fluid balance then was kept up by daily infusions or by infusions as necessary. Following hydration, plasma or whole citrated blood was given to give the child a boost. Other such infusions would follow as indicated.

Fluids by mouth were given to all cases from the start of treatment. Weak tea, 5 per cent karo, water, sodium lactate solution, Hartman's solution, or 5 per cent barley water were offered between feedings and allowed to the maximum tolerated. With few exceptions, formula feed-

ing was started at once. The formula consisted of a high protein milk, low carbohydrate mixture. This usually was reconstituted protein milk, Dryco, skim lactic milk, boiled skim milk, and acidified evaporated milk. The initial mixture was usually dilute. This was rapidly strengthened and as the infant improved, carbohydrate was added and the per cent fat increased. Six or seven feeds a day were given. The infant was allowed all it desired of the formula. It was immediately increased if the infant was not satisfied. A period of 12 to 24 hours' starvation was practiced in only a few cases.

Vomiting was a rare occurrence. This was handled by gastric lavage followed by a feeding or else by a period of starvation during which time fluid balance was kept up by subcutaneous or intravenous fluids. Formula feeding was started as soon as possible.

By this routine acidosis and dehydration were combated with fluids by mouth and fluids by intravenous and subcutaneous route. Shock and protein loss were met by plasma and whole blood. Weight loss was combated by beginning a formula at once or as soon as occasional gastric upset permitted.

Kaolin-pectin preparations were extensively used. Banana powder and apple powder less often. The opiates, as tincture of opium, and the comphorated tincture of opium, were used extensively in all but five cases.

### RESULTS

Table 3 shows that the greatest number of deaths occurred in the group receiving only dietary, supportive, and infusion therapy as described above. This 30 per cent is higher than the fatality for the entire group of 23 per cent. The cases receiving sulfonamides show a very low case fatality. Henderson<sup>3</sup> has reported good results with the use of sulfoguanidine. In this group sulfasuxadine was more often used.

TABLE 3

|                   | Recovered | Average Hosp. Stay | Died | Total | Percent Case Fatality |
|-------------------|-----------|--------------------|------|-------|-----------------------|
| No Sulfonamides   | 14        | 13 days            | 6    | 20    | 30                    |
| Sulfaguanidine .  | 2         | 19 days            | 1    | 3     | 14                    |
| Sulfasuxadine ..  | 9         | 22 days            | 1    | 10    |                       |
| Sulfadiazine .... | 1         | 9 days             | 0    | 1     |                       |

This shows that opiates, and Kaolin-pectin mixtures did not exert any effects since both the sulfonamide group and those without sulfonamides received extensive use of these medications. The sulfonamide group shows such a marked difference as to warrant more extensive use in such epidemics.

Of the eight deaths, there were no complications or physical findings to explain them. Death

usually followed the syndrome of severe dehydration, acidosis, circulatory collapse, continuous yellow liquid stools, hyperpneic breathing and failure of the infant to respond to heroic efforts to combat these findings with measures as described. Coma would follow and deepen till death supervened.

### DISCUSSION

Our experience with this type of infantile diarrhea leads us to feel that any early beginnings of diarrhea in nursery or institution should be met with immediate and rigid measures. Treatment should be persistent, constant, and vigorous. The physician should keep the infant under observation for a period of 10 to 14 days during improvement and weight gain. He should not be fooled by periods of regression. The sulfonamides should be given in adequate dosage.

### CONCLUSION

A series of cases from a severe epidemic of diarrhea of the newborn is reported. The treatment as outlined produced very favorable results. Response to sulfasuxadine was very favorable.

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### Routine Chest X-rays

Only universal X-ray examinations of the chest of all patients, regardless of the nature of their complaint, could lead to exclusion of the tuberculous. The University of Chicago Clinics and the affiliated Provident Hospital have X-rayed all clinic admissions for some years with most beneficial results. As a method of avoiding contamination, however, this is only part of the necessary effort. As a means of keeping tuberculosis out of hospitals, pre-admission X-rays would lead to an unnecessary increase in the rejection of patients badly in need of care.

Many patients will always enter hospitals without a previous examination, and they can not be asked to leave if tuberculosis is discovered. Even if a discharge could be effected without harm to the patients, where should they go for treatment? Tuberculosis hospitals could hardly be expected to engage in the treatment of all extrapulmonary, non-tuberculous conditions. Sanatoria are usually not located or staffed for the purposes of general medicine and surgery. Many communities have no facilities specifically intended for the treatment of patients with tuberculosis.—Tuberculosis Control in Hospitals, Robert G. Block, M.D., *NTA Bulletin*, Aug., 1944.



# Juvenile Delinquency

DOROTHY E. DONLEY, M. D.

WAR, with the immediateness of its reality, splits emotional "synthetics", revealing forgotten roots. In the recent *Bulletin of the American Association for the Advancement of Science*, (January, 1944), Otis Caldwell calls attention to the constructive aspects of this most terrible of all wars. "War problems are insistent. Directness and intelligence of attack are imperative. Testing of results is done quickly and in terms of human values. Indeed, validity of ideas and of their application reaches a high level. Personal interest in a given discovery must disappear within the larger interests of many people." We whose common interest is in relieving suffering, and restoring, and preserving normal function must look to find constructive factors in the rearranging of relationships, brought about by the forces dependent on or interwoven with war.

## A SOCIAL THREAT

Contrary to popular impression, I believe we can agree that juvenile delinquency has not become a greater social threat, because of the war. The pathology, which the professions recognize under the term "juvenile delinquency", has been mounting in seriousness with each year, but now, in the white incandescence of war, true proportions are seen and the alarm has reached the laity. In the past half-century, the professions of law, church, social science and medicine have come to realize fully that there is no neat "specific". Treatment aims have had to be melioristic.

We have felt that the school and the home, since they are natural habitats of the child, should be the institutions to treat the child's difficulties but, in a society where the advertised goals are all negative—freedom from want, freedom from fear, from religious and educational oppression, it has been difficult to "sell" the positive corollaries. The inconsistency between adult practice and ideals, that figures largely in etiology of neuroses and delinquency in intelligent children, appears to be beyond the ability of the adults to correct. They continue placing individual satisfaction supreme, actually teaching so by example. Consequently, it has been difficult to convince children of the value of a social adjustment which placed obstacles in the way of satisfying their personal appetites.

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The war gives children the opportunity to learn, not by example, but by experience, the higher value of self-sacrifice,—the enduring of fear, want, oppression, for a greater good. The question of how to motivate the young towards social adjustment was and is a threatening question for public schoolmen. The character-training books, formerly neglected or ignored, are being taken from the shelves with respect. But, here and now, the youth that was showing affective blunting, a loss of emotional vigor, is now having an "edge" put on its emotions. The grinding wheel is rough, and the process is painful, and there are many whose steel, their constitutions, is so poor that they can not "take it". This we know from the psychiatric morbidity among the disability discharges from the armed forces. But the sound steel takes the sharpening, profiting by it.

## THE BACKGROUND

For us who carry on, the meaning of juvenile delinquency must be re-examined. For background, I recommend the bibliography of Healy, the Gluecks and Lewis J. Doshay. Society has its rights. In aggressive anti-social behavior it sees a real threat to its solidity. It is a prime necessity for social safety that guilt be assigned to delinquent acts. The law has this function, and it is imperative that that agency should not abandon it. But it is equally true that anti-social behavior has a specific meaning to each individual. As therapists, it is our function to consider the individual, find out and treat the underlying cause.

However, in times like these—of crisis—when "intelligence and directness of attack are imperative" there is a tendency to an abuse of authority. It has been my observation that such a tendency

Address given at St. Elizabeth's Hospital, Saturday, February 19, 1944, Washington, D. C., at the Mental Hygiene Symposium, under auspices of District League of Nursing Education.

is growing, to judge by the radio adviser who urged an unqualified return to the "rod", and the group leader who felt he must rule rather than lead. Authority is not a personal attribute, but resides in any person only as an instrument of order, natural and supernatural, in the universe.

Authority enforced without the giving of intelligent reason can hardly expect to be accepted in this country of democratic ideals. The child needs to be given an interpretation and the person using authority must know his rights and responsibilities. This approach calls for intelligence, integrity and humility on the part of the worker with children, and a willingness to persevere in meeting the needs of the young without counting the cost. "Human progress marches only when children excel their parents." (Herbert Hoover—White House Conference).

The practical difficulties of maintaining relationship of a personal nature with the child while at the same time enforcing the minimum of social standards are well known to those who work in the schools and the courts. The clinic all too often fails, in maintaining the value of the individual, failed to understand that delicate balance, but I believe this situation to be somewhat clearer. Dr. Plant ("Personality and the Cultural Pattern," Commonwealth Fund, 1940) has said that if the court and clinic have mutual respect for one another, and if the functions of each are well defined, then there is no reason for antagonism between apparently contradictory authoritative and therapeutic points of view.

#### RESENTMENT

For the delinquent individual, anti-social behavior means that he or she has resentment and is able to externalize it. This latter ability is no mean talent, and psychiatric experience indicates it is an asset in that it is a protection against functional psychoses.

Now, for the source of this resentment. Hubert's mother wanted to continue traveling, as she had done for the preceding five years, with her husband, but he wanted them to have a baby. So to keep her husband's affection, she "had" Hubert. She resented the baby all through her pregnancy. After he was born she was unhappy because she had to stay with her mother-in-law. Hubert complicated the picture by crying all night for three months. He was always hyperactive and as a toddler was tied up in the back yard. He developed a skin rash which did not yield to any medicine. He was not liked by any of the boys he finally found to play with, because he was awkward and rough. Superseding the skin rash, came asthma and the resulting need for maternal care, a care which bore little fruit for the asthma persisted.

He was never trusted by his mother to do anything because he was too flighty. The last blow to her maternal pride was struck when Hubert began taking pennies from her purse. He got along well enough with his father, but his mother interrupted their friendship when, by her ill health, she required a great deal of attention from her husband. His mother used the strap freely with no improvement. In desperation, she turned to the church, but Hubert's insecurity persisted.

Some children in spite of such habitual insecurity, by developing a special skill, come to know a feeling of adequacy. "Even if I don't belong, it doesn't matter, because I can now take care of myself." School success frequently accomplishes this, but Hubert was deprived of this substitute because in the first grade he was too restless to make him anything but a conspicuous failure. With his intellectual ability well above average, but unrecognized, he was considered a dumbbell by his fellow students and his teachers, and finally a nuisance.

He needed the money he stole from his mother's purse to buy protection from the gang. He found this make-shift successful for his purpose and instinctively began to develop a sense of satisfaction in the field of his success—stealing. Finally he took a cheap watch and money from the members of the school faculty. Then there followed pressure, new to him, the threat of being turned over to the court for punishment.

Here his behavior took what looked like an odd turn. Soon the school called his mother to tell her that Hubert had reported to the principal the loss of \$17.00 from his pocket. The school didn't believe him. For the first time Hubert's mother was placed in a position where she had to take Hubert's part against that of the school. Yes, Hubert had the money. She knew because he had stolen \$20.00 from her the day he reported the loss. When she accused him of it, he had wept, saying he couldn't return the money because all but three dollars of it had been stolen at school. Hubert, possibly for the first time in his life, had maneuvered his mother to his side. More than that, by his apparently bizarre behavior, he had so impressed the school with the meaningfulness of it that they suggested treatment from a clinic instead of punishment by the court.

Instinctively Hubert—and he may never realize that he did it—contrive to evade the court, which would be obliged to consider chiefly the crime, and to enter the clinic which is duty bound to consider chiefly the criminal! By devious and unrecognized forces of his own, this fourteen-year-old has already earned the respect of us, who try to learn all the modes of communication in man. Subsequently Hubert, working with the



clinic, has directed his strength in socially accepted behavior.

#### THE SCHOOL'S PART

The part which school failures play in delinquency is being reemphasized—and justly so. The normally intelligent boy who has been unable to learn to read or write or spell, and whose difficulty has not been correctly diagnosed, has sufficient cause for a terrific amount of resentment. If he achieves adequacy through success in other fields, he may find this resentment converted towards social ends. However, such a transformation being absent, it takes very little more in the way of misunderstanding or mishandling to precipitate a major break.

Charles' criminal career was climaxed by the burning of a \$100,000 grain elevator. Since the age of six his community had refused to accept any other estimate of him than that of a "dumbbell". Examination showed normal intelligence,—but he was a non-reader. In addition to the thwarting in school, his family rejected him because they identified him with his father, unsuccessful, and the "town drunkard". There were no money-making opportunities open to him in this small town, where he was so conspicuous a school-failure.

His resentment grew until, after experimenting with the idea of fire for some time, he, accidentally, set a small explosion which ignited the elevator. He had not intended to set the fire that day, and so had a superficial alibi for his crime. He could not accept the guilt, resented his incarceration, on which his community insisted, and seemed well in the toils of the vicious circle toward lifelong criminality.

#### THE ENVIRONMENT

Failure of the child and the environment to become integrated in a manner satisfactory to both may lie largely in the environment, or largely in the child. In many cultures the environmental needs of the intellectually inadequate child have been poorly met. In our time, the more aggressive of these protest with primitive "gory" crimes.

The environmental need of all children to be the most valuable and desired of man's achievements is not being met by our culture, which has been led to place material security above them. The average child of today, (if it achieves existence, and survives the threat of disposal in the sewage system), must compete in its first breath, with parental ambition for a "snug suburban home," and a socio-economically successful parental career.

The needs of the so-called "privileged child" of our intellectually and economically superior parents are not being met in that he is conditioned to ambitions that are for the most part

not realistic ones, based on intellectual values at the expense of emotions.

My purpose in these few remarks has been to throw into relief one or two observations concerning lawbreaking in young people. Each case has unique features, but one additional point we must recognize. Certain fads in crime sweep epidemic-like, through groups, contagious to those who have not had active immunity created by self-confidence and social competence; or to those who have not had a precarious immunity induced by fear-stimulated deterrents. Direct community action for prevention is astir and in need of leaders.

I will take a few moments more to suggest that one keep in mind, in community planning, the principles taken from the Glueck study in 1936:

1. Crime prevention programs should take into consideration the evidence that most criminals show definite anti-social tendencies of attitude and behavior in early childhood.
2. Existing community agencies and institutions should be used to their full capacity. The public and parochial schools can play an especially significant role.
3. Crime prevention programs should recognize that children should have ample outlet for their energies.
4. Intensive work with problem children, and delinquents, and attitudes and prejudices of parents must not be ignored.

The present interest in professional group work (Slavson-Group Therapy-Commonwealth, 1943) is encouraging and promises to bring better functioning by better mechanization of our existing social agencies, school, church, and recreational centers, to carry out the community program.

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Previously I said "diabetics have all the eye-troubles that others have and do less well with them." This is another generality which sounds well but is not the whole truth. It fails to cover all the known facts. In 4 out of 11 young diabetics we had retinal hemorrhages lowering visual acuity, we had 20 cases with retinal hemorrhages of a type seen only in diabetics, we found more anterior chamber bleeding in diabetics after lens extraction; individual retinal hemorrhages in diabetics were slow to disappear and in general retinal hemorrhage did not regress and we saw more blood in the retinae of the older diabetics than in non-diabetics of the same age, whatever other changes were seen.—Harry C. Messenger, M.D., Providence, R.I.; Rhode Island Med. Jr., Vol. XXVII, No. 12, Dec., 1944.

# Sulfonamide Treatment of Gonorrhea: Some Factors Affecting Its Efficiency

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FOR some time it has seemed to us that sulfonamide therapy of gonorrhea has been much less effective in our hands than usually claimed. It is commonly stated that 80 per cent are cured by sulfathiazole alone. In an analysis<sup>1</sup> of 2,500 pooled cases by the American Neisserian Society and the U. S. Public Health Service, published in 1943, 86 per cent were asymptomatic (but not all bacteriologically negative) after three weeks of sulfathiazole, 84 per cent after three weeks of sulfadiazine, 85 per cent after sulfapyridine, 68 per cent sulfamerazine, and 62 per cent sulfanilamide.

In recent months there have also been less favorable reports. Swan<sup>2</sup> reported a 56 per cent cure rate with sulfathiazole alone; Weinert and Scala<sup>3</sup> considered results "satisfactory" (remission of symptoms within 10 days, without complications) in only 34 per cent of their series. When their "satisfactory" class is enlarged to include those who were symptomatically cured within three weeks, the percentage is increased to 46 per cent. Other medical officers in military service have also expressed to us their dissatisfaction with sulfonamides in gonorrhea.

We have had the impression that sulfonamide treatment of this disease is becoming progressively less effective. To determine this point, the 126 cases treated with sulfonamides at this Marine Corps Air Station since July 1, 1943, have been divided into three periods rather arbitrarily—before November 1, November 1 to March 1, and March 1 to May 10. The analysis confirms our impression, as indicated in Table I.

TABLE I

|            | Number Cases | % Cured |
|------------|--------------|---------|
| Period I   | 26           | 65%     |
| Period II  | 51           | 51%     |
| Period III | 49           | 43%     |

In this study the criteria of cure were (1) complete cessation of discharge with no recurrence when treatment was discontinued, (2) inability to obtain any purulent discharge on stripping the urethra two days after treatment was discontinued, and (3) a urine at the time of release from sick bay which was perfectly clear in the second glass and contained no more than an occasional small shred in the

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first. The prostate was not massaged prior to discharge from sick bay in recent acute infections; however, these men were all observed for several weeks after return to duty, and many had massages then. Prostates were massaged in all chronic or recurrent cases, and the prostatic fluid required to be negative on direct smear. No cultures were done. A slight persisting purulent discharge, even if the smear was negative, was not considered a cure. A patient was considered a failure if he did not meet the above criteria after two 10-day courses of one or more sulfonamides, or if drug reactions prevented adequate therapy.

The recent study of Carpenter et al<sup>4</sup> indicates an extremely high effectiveness against certain strains of gonococci in vitro, but an increasing incidence of sulfonamide-resistant strains since the widespread use of these drugs. We have not had the facilities to conduct such studies on our material, but it seems likely that the results would be similar.

During Periods I and II many of the men received 1 Gm. six times daily, while the others were given 1 Gm. four times a day. In both instances an initial dose of 2 Gms. was usually given. Table II indicates that the larger daily dose and more frequent administration were no more effective. To determine whether there might be any advantage in a larger initial dose, during Period III an initial dose of 3 Gms. was given, followed by 1 Gm. q. i. d. It will be seen from Table I that this did not alter the declining effectiveness of sulfa treatment.

TABLE II

|              |          |           |
|--------------|----------|-----------|
| 1 Gm. 6 i.d. | 32 cases | 53% cured |
| 1 Gm. 4 i.d. | 46 cases | 57% cured |

More frequent administration and larger daily doses likewise did not bring more rapid cures, as shown in Table III. Regardless of dose, most of the sulfonamide "cures" had a complete cessation of discharge within one week—often within three days.



TABLE III

|                         | 1 Gm. 6 i.d. | 1 Gm. 4 i.d. |
|-------------------------|--------------|--------------|
| Dry within 7 days ..... | 59%          | 67%          |
| 7-14 days .....         | 30%          | 15%          |
| Over 14 days .....      | 11%          | 17%          |

(Percentage here refers to per cent of cases cured, not the total cases.)

During the first two treatment periods all patients except those with epididymitis were kept ambulatory, on light ward details, and granted liberty on the station. Since the value of bed rest in gonorrhea has been preached for many years but applied in practice relatively infrequently, during the third period a number of unselected cases were put to bed except for meals and toilet privileges. In this small series there appeared to be a slightly more favorable result in those who remained in bed, as shown in Table IV. Furthermore, those with very profuse discharges and marked swelling showed a more rapid amelioration of these symptoms when at bed rest.

TABLE IV

|                  | Number Patients | % Cured |
|------------------|-----------------|---------|
| Bed rest .....   | 21              | 48%     |
| Ambulatory ..... | 28              | 39%     |

Sulfathiazole was the drug used in most cases; sulfadiazine was used in 29 cases, chiefly when sulfathiazole had been ineffective. It failed in each of four instances when used as the primary drug; it was effective in one sulfathiazole failure but failed in 24. Sulfathiazole was apparently successful in 4 cases after sulfadiazine had failed but was ineffective in three. Three recurrences followed sulfadiazine therapy, a much higher percentage than the seven which followed sulfathiazole. In our hands sulfadiazine has been almost useless.

The problem of recurrence is an important one, and we were curious to see what effect duration of treatment might have. We are convinced that the frequently recommended 1 Gm. q.i.d. for 5 days is inadequate. Table V indicates that the incidence of recurrence when treatment is continued for 10 days or more, even if the discharge has ceased, is less than one-third the incidence when treatment is given for less than 10 days. Of the recurrences, two-thirds responded to further sulfonamide therapy, plus prostatic massage when indicated (three cases).

TABLE V

Treatment under 10 days: Cured 16; Recurred 8 (33%). (Of these 5 were cured by further sulfathiazole therapy, 2 were resistant; one received no further sulfa drug).

Treatment over 10 days: Cured 46; Recurred 5 (10%). (Of these 3 were cured by further sulfathiazole therapy, 2 were resistant.)

Of the 126 cases treated, 13 developed drug

reactions sufficient to discontinue therapy. In three of these the reactions occurred before enough sulfonamide had been given to judge its effectiveness. Of the remainder, 5 were cured by sulfonamide therapy alone.

## COMMENT

Despite waning effectiveness, sulfathiazole is still a useful drug in treatment of gonococcus infections. At the present time, when penicillin is not generally available, it remains the first therapeutic weapon in this disease, although it alone will fail to cure an ever-increasing number.

When penicillin is not available and fever therapy for resistant cases not readily accessible or contraindicated, it would appear that bed rest from the beginning of treatment would give a somewhat better chance of sulfonamide cure. Sulfathiazole should be given 1 Gm. q.i.d. for 10 days, even though the discharge may cease earlier; in resistant cases several courses may need to be given, combined with rest and judicious local therapy, gently administered. It should be unnecessary to point out that the physician must watch carefully for drug reactions, and question each patient in regard to previous use of these drugs, reactions, and kidney and liver disease.

When penicillin is available in limited quantities for sulfonamide-resistant cases, we believe ambulatory treatment rather than bed confinement is justified, barring such complications as epididymitis and arthritis, and provided the patient can be depended upon to carry out treatment faithfully and refrain from spreading the disease. Although a few more patients may require penicillin on such a program, many will be cured without loss of time from work; the cost of the penicillin will be less than the economic loss to the patient and—most important at this time—loss of man hours to the military organization or to industry. If the patient is not cured within 10 days, he should be given penicillin.

When penicillin becomes generally available in adequate amount to meet the demand, it appears that it will replace sulfonamide therapy of gonorrhea. Despite the dramatic results obtained thus far, however, failures with the usual dosage do occur, and it may be well to restrain unbounded optimism for a few years. Our experience with penicillin will be reported in another paper.

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# Current Thinking In the Field of Allergy

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**T**HIS last year has seen a realignment of organizational forces in the field of allergy in this country as illustrated by the merger of the Association for the Study of Allergy and the Society for the Study of Asthma and Allied Conditions. So, we now have two strong societies, the new American Academy of Allergy and the older American College of Allergists. Each has an excellent magazine as its official organ. *The Journal of Allergy* for the Academy is a little too technical perhaps for the average physician reader and the *Annals of Allergy* for the College more interesting and lively and possessing much more appeal for the general medical reader. As a result of all of this we find ourselves well organized and stimulated by competition to make progress in this new field of internal medicine.

The new society, The American Academy of Allergy, held its first meeting in New York last month. The program was a strong one. Taking a clue from the recent meeting of the Annual Forums on Allergy and the Chicago meeting of the College last June, the committee arranged for a good deal of fundamental physiology and immunology.

David Barr, president-elect of the American College of Physicians, made a good talk in which he gave allergy an important place in teaching medicine and deplored the fact that most internes and residents went into practice with a very meager conception, if any at all, of the part that allergy plays in medicine. In fact, he said all too often they have a bad impression of its practice and this only gleaned from hearsay. He put forth a challenge to all of us who do teaching and especially the heads of medical departments and chiefs of services to correct this and promptly.

Paul R. Cannon, chairman of the Department of Pathology in the University of Chicago, spoke on "The Nutritional Aspects of Globulin Metabolism". He pointed out from his own work and that of others that antibodies were after all only modified globulins and therefore protein depletion interfering with globulin formation is bound to be accompanied by a failure in antibody production. He presented results which show that the more complete the proteins of the dietary are, the more quickly and successfully will the animal be able to resist and overcome infections. The modern leaders who insist that we must lower our standards of living by adopting a cereal diet forget or do not know about this

important fact which Dr. Cannon has been urging upon the American medical profession for some time now. I personally think that we physicians should get excited enough to tell all who will listen about the importance of milk, eggs, and meat in our diets.

Eugene Landis, The George Higginson Professor of Physiology at the Harvard Medical School, discussed in most brilliant fashion "The Factors Influencing Capillary Permeability". We are gradually amassing evidence which will enable us to understand this, one of the basic problems of the allergic reaction. He discussed the chemical, the anatomical and the mechanical factors involved in the passage of a transudate. The new mechanical factors are concerned with the studies on serum protein and their size and shape and so we are brought back to a consideration of much that Dr. Cannon had in his talk.

Carl A. Dragsaet, professor of pharmacology in the Northwestern University Medical School, brought us up to date on "The Significance of Histamine in Anaphylaxis". This was fully the equal of his address on the same subject before the Fifth Annual Forum on Allergy in Cleveland in 1943 and brought those in attendance up to date on the ever increasing evidence that histamine is released in the allergic reaction.

Hans Selye, associate professor of Histology in the McGill University, discussed his "alarm reaction" under the subject, "The Disease of Adaptation". This is the most stimulating conception that has been presented in recent years and vies with the biologic responses as they have been ferreted out by William F. Petersen of Chicago, or the effects of climate as they have been studied by Clarence Mills of Cincinnati.

For the toxic or noxious agents which Selye has studied, be they chemical or emotions, set a pretty regular series of responses. First there is the period of response in which there occurs changes in the lymphoid tissues, the adrenal cortex and many other anatomical changes. This is followed by an adaptation to the noxious agent, but to me the significant thing is that while adaptation has been accomplished it is apparently at the expense of the individual's relation to other environmental factors. For instance if the noxious agent is a noise, the animal will finally adapt himself to it but at the same time he shows greater susceptibility to other noxious agents; as for instance formalin fumes which he formerly, or any other normal



animal, could have withstood easily and without discomfort but which now become highly poisonous.

Why, then, could not the emotional strain of our industrial life make tobacco, for instance, much more toxic to us than to the out-of-door man? Why can't tobacco and other noxious agents be that much the worse for the allergic? I am trying to say that Dr. Selye's address was most stimulating. Recognizing the changes in the adrenal cortex, he showed what would happen to the animals if one of chemicals derived from the cortex was given daily over a period of time. Extraordinary lesions appear like many that are still unexplained in human pathology.

The general run of papers by the allergists themselves showed the effects of three years of war upon research. J. Warrick Thomas extended his observations on allergic manifestation in the human eye by discussing the corneal lesions. A. B. Berresford presented data on the moisture content of pollen—a technical question of some importance in the preparation of pollen extracts. This factor, however, should be correlated with the antigenic properties of the pollen for the initial water content may well be accompanied by a "better" protein content. Moisture absorbed by storage is another matter—it only makes for moldy specimens and deterioration.

J. Harvey Black reported a large series of cases of hives treated by vitamin K because of the increased capillary permeability in these cases and reported good results. The worth of the paper in my estimation was that it serves to focus the attention of the allergist upon liver functions—a thing which some internists have recognized before. W. C. Spain and his assistant presented an active, stable poison ivy extract in normal saline solution for which they claim a good deal.

The outstanding research reported was that of Frank Simon on the fact that human dandruff gives skin reactions in certain cases of atopic eczema and that patients do better when the dandruff of their mothers' or nurses' is controlled.

Francis Rackemann of Boston discussed what he called "depletion" in asthma. He was not quite clear himself on just what he meant but in general he urged that we look at the patient with the asthma in terms of nutrition, aging, mineralization, as well as that of immunology.

Finally there were the routine papers of such a gathering. A confirmatory paper by Milton Cohen and H. J. Friedman of Cleveland reported the treatment of ragweed hay-fever with antibody neutralized extract. Oscar Swinford of Virginia read a paper on "Reactions to Pneumococcus Antiserum"; reversed anaphylaxis in the guinea pig which would have attracted more

attention in the days before chemo-therapy. Harsh of San Diego reported on fungus content of the air of Southern California throughout the year. Armand Cohen of Louisville presented data to show that nicotinic acid was of little help in the treatment of asthma as had been alleged previously by some British workers.

Abraham Walzer of Brooklyn gave his work on the transportation of antigen through the body by electrophoresis. Louis Tuft of Philadelphia made another report extending his studies on the variations in allergenic activity of food extracts. This work has great practical importance. Finally, Sam Feinberg of Chicago reported how most people working in a plant became sensitized to azochloramid during the process of its manufacture. Since this chemical is used in great quantities for the disinfection of drinking water, this became a major problem at once.

Not only did the war take its toll of the quality of research presented, but also in the way the meeting had to be run. The order of the program could not be followed at all and so the only way to hear the paper that you came a long way to hear was stay in your seat and hear them all, for there was no way of telling what was coming next.

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### The Surgical Treatment of Gall Bladder Disease

In the vast majority of patients, the relief of symptoms following cholecystectomy is complete and gratifying to both patient and surgeon. Unfortunately we have all seen the occasional patient who is not relieved of symptoms or who is worse after operation than before. Failure to achieve a satisfactory result is most frequently due to failure to make a satisfactory diagnosis, i.e., to remove a gall bladder which is nearly normal, and overlook some other cause such as pancreatitis, duodenitis, spastic colitis or some other abnormality. Careful evaluation of the evidence of cholecystic disease before operation is the most effective way to avoid this pitfall. Another cause of poor results is a poorly performed operation, such as overlooking a stone in the common duct, incomplete removal of the gall bladder, or extensive trauma at the time of operation leading to excessive production of adhesions. With accurate diagnosis and a satisfactorily performed operation, good results should be expected and attained.—Max M. Zinninger, M.D., Cincinnati, Ohio; The Jr. of the Michigan State Medical Society, Vol. 43, No. 12, Dec., 1944.

# Reconstruction of Common Duct by Means of Vitallium Tube

ERNST STERNFELD, M. D., and WM. H. MEFFLEY M. D.

VARIOUS devices and means have been suggested in the literature to reconstruct or replace a common duct which has undergone pathological changes or has been subject to trauma during surgery. Very recently it has been suggested that a Vitallium tube might be used for that purpose and a case in which this procedure was carried out successfully is here-with presented.

Mrs. R. B., patient No. 41125, age 34, presented herself three years ago for cholecystectomy which was advised by her family doctor for a calculus condition of her gall bladder which had caused a series of painful attacks. A cholecystectomy and appendectomy were done. No stones were found in the common duct. The cystic duct and artery were isolated, cut and tied separately. The patient made an uneventful recovery and felt fine until December, 1941; however, she was twice admitted, giving a history of vaginal bleeding, the bleeding being so profuse on second admission as to require transfusions. No pathology was found on pelvic examination and the curettings did not contain any tissues. A hemolytic type of anemia was suspected because of the presence of a moderate degree of jaundice, but all liver function tests and blood tests failed to exhibit any definite pathology.

In December, 1941, she developed pains in her upper abdomen, distention and commenced to lose weight. There was a moderate degree of jaundice present but stools contained an ample amount of bile. She caught a cold and subsequently developed pneumonia. When admitted to the hospital patient was in bad shape. Her admission hemoglobin was 28, but with transfusions and the use of sulfonamides, recovery was speedy.

In order to throw more light on the persistent jaundice, abdominoscopy was done and a diagnosis of hepatitis and cholangitis was made. The patient returned to her family physician for medical treatment, but gradually became worse and was re-admitted to Flower Hospital, in May, 1942, following a severe intestinal hemorrhage which lowered her hemoglobin to 25 per cent. Again she recovered rapidly with multiple transfusions. At that time she was so emaciated as to allow for the first time palpation of a tumor underneath the greatly enlarged liver.

After pre-operative preparation an exploratory laparotomy was done on July 27, 1942, and an unusual pathology was found. A cystic tumor about the size of a lemon was obstructing the structures of the hepatic ligament, the origin of this cyst apparently being inflammatory. No evidence could be found of a neoplasm.

An attempt was made to remove the cyst in toto but while dissecting it the tumor was broken into and about 60-80 c.c. of clear watery fluid escaped. It was impossible to save any of the contents for examination, but part of the cyst-

## The Authors

• Dr. Sternfeld, Toledo, Ohio, is a graduate of the University of Vienna, 1937; junior member, American College of Surgeons; junior surgeon, Flower Hospital, Toledo.

• Dr. Meffley, Toledo, Ohio, is a graduate of University of Michigan Medical School, 1930; fellow American College of Surgeons; attending surgeon, Flower and Toledo Hospitals; senior radium therapist, Lucas County Hospital.

wall was removed for microscopic examination. An attempt was made to identify the common duct. This was unsuccessful because it had collapsed under the pressure of that cyst. When attempting to identify it by puncture with a No. 18 needle, a vessel was entered into, requiring packing of that area for control of bleeding. The abdomen was closed about that pack and four drains.

The patient recovered from the operation and subsequently developed a complete biliary fistula. Her condition improved temporarily with replacement therapy but on the whole the course was rather down hill, most likely because of the great loss of bile salts and essential minerals through her biliary fistula, incomplete digestion of food and persistence of her cholangitis.

In September, 1942, a cholangiography was done through the biliary fistula showing tremendous distention of the intra-hepatic ducts and collection of the oil in the area which was previously occupied by the cyst and which by that time formed an abscess cavity since intermittent evacuation of purulent material was observed during the time of post-operative follow-up.

Since the patient kept on losing ground, it was suggested to the patient's husband that an anastomosis between the hepatic duct and the duodenum should be attempted and use of Vitallium tube seemed to be the best means to accomplish this.

The operation was carried out on September 29, 1942, resecting the biliary fistula and the biliary abscess cavity and anastomosing the hepatic ducts at their confluence to the common duct with the duodenum, using silk sutures for fixation of the tube.

The post-operative course was stormy for a few days and there was a small biliary fistula apparently due to moderate leakage around the anastomosis for 10 days post-operatively, which closed spontaneously after that time.

The patient improved rapidly. Her stools, which had been acholic ever since early 1942, became brown. When last seen, August 26, 1943, eleven



months after the operation, the patient had gained 28 pounds and felt fine, was able to do her own housework and commenced to enjoy life again. X-ray examination showed the tube in the same position as placed during the operation.

#### DISCUSSION

This case is recorded as further evidence that Vitallium tubes are very practical in reconstruction of common ducts. Considering that the operative field was entered into twice before and that the operation was carried out in the presence of a biliary abscess cavity complicating visualization and dissection of all structures involved, the total operative time of two hours and twenty minutes must be considered as relatively short, and a short operative time was essential to carry this debilitated patient through an operation. We feel that the relatively easy and short maneuver of opening the duodenum, inserting the tube and implanting it into whatever remnant of the common duct can be indentified, helped greatly to reduce the operative time, since accurate suture in relatively great depth is avoided and but little difficulties are encountered in approximating the structures without tension.

In addition to the interest in the mechanical and technical problem of this kind of anastomosis we feel that the case is also of interest from the clinical side because of the unusual pathology found at the second operation. Whether the obstructing cyst was a consequence of a technical error at the first operation or was an independent pathology can not be decided, but, regardless of its origin, it has to be considered as very rare. The case is further of interest because of the accompanying cholangitis, which has apparently been greatly improved since the relief of obstruction and return of the bile flow into its original milieu.

#### REFERENCES

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2. Bancroft, F. W.: "Operative Surgery," Appleton Century Company, 1941.
3. Zininger, Max M.: "Surgery in Patients with Jaundice," Paper read at Academy of Medicine of Toledo in Lucas County, April 24, 1942.

Sound public health practice demands that the method used in mass radiography for the control of tuberculosis be one which benefits the largest number of persons in industry or the community. When available funds are limited, it is of greater value to examine 100,000 persons with small films and miss a few minimal cases than to examine only one-tenth of that number at about the same cost, using large celluloid films and leaving 90,000 persons without benefit of any X-ray examination whatever.—H. E. Hilleboe, M.D., and D. M. Gould, M.D., Jour. A.M.A., May 24, 1944.

## KEEPING UP WITH MEDICINE

THEY tell us that there is three times the amount of vitamin C in the peel of an apple as there is in the flesh.

\* \* \*

PIGMENTATION of the skin is often suggested in the diagnosis of cirrhosis, especially pigmentation in the creases of the palms of the hands, the axillary folds, and over the back.

\* \* \*

IF the gall bladder is smooth, palpable and not tender, the chances are great that there is a cancer of the extrahepatic biliary tract most often in the head of the pancreas.

\* \* \*

THERE is sufficient histopathologic proof to question the rationale of total expurgation of a sinus mucosa under certain circumstances, even though some rhinologists will claim complete cures by such radical procedures. Clinical experience also has demonstrated that in most instances this sinus infection will correct itself if and when favorable conditions are established.

\* \* \*

IN catarrhal jaundice (hepatitis) chills may occur early in the course of the disease (often before the onset of jaundice). When the jaundice chills are intermittent and recurrent, they nearly always indicate a common duct calculus—less often a stricture.

\* \* \*

TO you who remain unconvinced that a temporary letup in our strenuous way of living is necessary, your attention is called to the names of physicians who have passed from our midst.

\* \* \*

PHYSICAL medicine will have an important role in the rehabilitation procedures of the future.

\* \* \*

WE are now getting confirmation of the faith and practice of the late J. F. Baldwin that surgical castration performed at the time of radical mastectomy will greatly enhance the patient's chances of overcoming the malignant disease.

\* \* \*

A REVIEW of the literature concerning the cold pressor test indicates that the mechanism is a vasopressor reflex reaction due to the stimulation of the cutaneous nerves of temperature and pain.

\* \* \*

MORE often than not the patient with chronic bilateral suppurative pansinusitis with polypi does not suffer from headaches.

\* \* \*

AS is to be expected we are now getting reports of dermatitis due to leg paint.—J.F.



# Pneumococcal Lobar Pneumonia Associated With Megakaryocytic and Leukoblastic Hyperplasia\*

J. LOWELL ORBISON, M.D., and THOMAS C. LAIPPLY, M.D.

**Case History:** F. J., a white male, 57 years of age, entered the hospital November 1, 1944. Except for slight dyspnea on exertion, he had been well until two days before admission when marked dyspnea began suddenly and continued. It was accompanied by cough and white frothy sputum. He had no chills or pain, nor had he noticed fever.

Examination on admission revealed a markedly dyspneic and cyanotic, obese, white male. Loud moist rales were heard posteriorly over the lower lobes of the lungs, and dullness was present anteriorly over the lower part of the right lung and over the apex of the left lung, anteriorly and posteriorly. The temperature was 38.5° C., pulse rate 136, respiratory rate 40 and blood pressure 120/80. The red blood count was 4.38 M. with 90 per cent hemoglobin (Sahli). The white blood count was 41,000 with 90 per cent neutrophils, 8 per cent lymphocytes and 2 per cent monocytes. The respirations became irregular and the patient died 8 hours after admission.

**Autopsy:** (No. 8612) by J. L. Orbison, M.D., disclosed lobar pneumonia in the stage of gray hepatization involving all of the middle lobe of the right lung and the upper lobe of the left lung. The other lobes of the lungs showed slight bronchopneumonia; the lower lobes of both lungs were partially atelectatic, and there was bilateral acute fibroinoleucocytic pleuritis. There was also hypertrophy (650 gms.) and dilatation of the heart, slight arterial and arteriolar nephrosclerosis, acute hyperplasia of the spleen, cloudy swelling of the liver, adrenals, and kidneys, hyaline necrosis of the arterioles of the pancreas, peri-adrenal fat, kidneys, seminal vesicles and small intestine, subacute aortitis and chronic leptomeningitis.

Cultures of cardiac blood and the lungs yielded hemolytic staphylococcus albus. Type I pneumococcus was recovered from the exudate in the left pleural cavity. Microscopic examination of the lungs revealed many large gram positive cocci (probably staphylococci) and a few gram positive diplococci that showed some "quellung" with type I pneumococcus anti-serum. There was also marked leukoblastic and megakaryocytic hyperplasia of the vertebral bone marrow. It was estimated that cellular elements constituted more than three-fourths of the marrow substance. Cells of the erythrocytic series were not increased. The megakaryocytes were increased to 294 per 100 high power fields or 6,800 per cubic millimeter of bone marrow (the normal number being 1,790 to 4,837 per cubic millimeter) (Fig. 1). Giant cells having the characteristics of megakaryocytes were also found in the small blood vessels of the lungs (Fig. 2), sinusoids of

liver, red pulp of the spleen and glomeruli of the kidneys. These cells were often elongated in the smaller vessels.

## COMMENT

R. J. Williams<sup>1</sup> states that in 1908 Dickson reported the occurrence of megakaryocytic hyperplasia of bone marrow in over 50 per cent of cases with pneumonia and septicemia. Williams

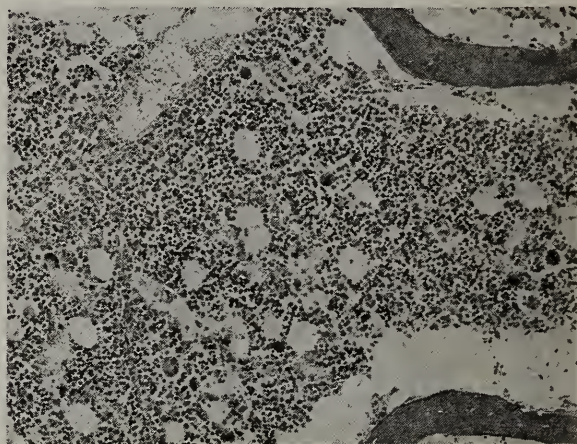


Figure 1. Vertebral bone marrow shows increased cellularity and many multinucleated megakaryocytes. H & E X 90.

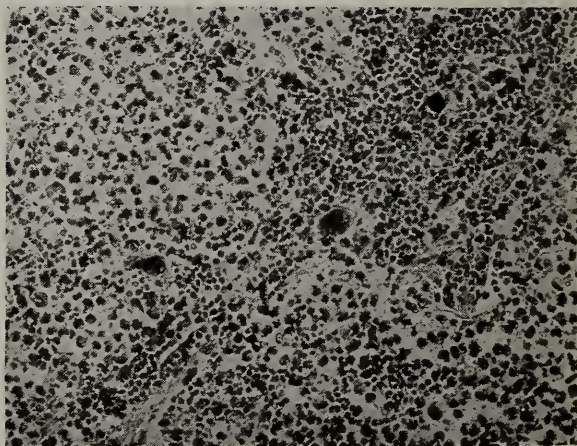


Figure 2. Exudate in pulmonary alveoli is rich in neutrophilic leucocytes. Megakaryocytes are in capillaries. H & E X 200.

also noted that subsequent reports on megakaryocytic hyperplasia indicate that pneumonia is one of the commonly associated diseases. In his own series of 306 unselected autopsies (primary hemopoietic diseases not included), Williams found 26 instances of megakaryocytic hyperplasia of

\*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the twenty-fifth of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems".



vertebral bone marrow. Of these 26 cases, 17, or 65 per cent, had primary pneumonia, and 9, or 35 per cent, did not. Only 39, or 12 per cent, of the 306 autopsies, had primary pneumonia and 267, or 88 per cent, did not. There is, then, a significant difference in incidence of megakaryocytic hyperplasia of those cases with pneumonia as compared to those without pneumonia. It was also noted that in bone marrow the megakaryocytic hyperplasia almost invariably parallels leukoblastic hyperplasia.

In determining the presence of hyperplasia of the vertebral bone marrow, Williams used the criterion of increase in the amount of bone marrow occupied by hemopoietic cells (normal ranging from  $\frac{1}{4}$  to  $\frac{3}{4}$  of the total marrow). Because of the wide range of normal values it was necessary to have at least one additional criterion. When the hyperplasia was of the leukoblastic type, the best criterion was considered to be the decrease in numbers or complete absence of the erythropoietic islands (normal ranging from 3 to 8 per high power field). Megakaryocytic hyperplasia was diagnosed when the number of megakaryocytes was increased to more than 210 per 100 high power fields, or more than 5,000 per cubic millimeter of bone marrow. Using these standards, the present case falls within the range of both leukoblastic and megakaryocytic hyperplasia.

Also of interest in this case was the presence of megakaryocytes within the small blood vessels of the lungs, sinusoids of the liver, red pulp of the spleen and the glomeruli of the kidneys. Since Williams' report was limited to changes in the bone marrow, no mention is made of the presence or absence of megakaryocytes in the visceral vessels. Downey<sup>2</sup> quotes Maximow (1889) and Aschoff (1892) to the effect that intact megakaryocytes may reach the circulation, but are always retained in the capillaries of the lungs. Downey also states that megakaryocytes are increased in the liver and spleen in myeloid leukemia and in osteosclerotic leukemia, and further reports that in a case of atypical myelosis there was marked increase of megakaryocytes in the sinusoids of the liver and the red pulp of the spleen.

In the case reported in this paper, there are two possible explanations for the occurrence of megakaryocytes in the capillaries of the viscera: they may enter the blood stream from the bone marrow, or be formed in the spleen and other organs of the body.

#### SUMMARY

This is the case of a 57 year old white male who died of type I pneumococcal lobar pneumonia. Autopsy revealed lobar pneumonia associated with megakaryocytic and leukoblastic hy-

perplasia of the bone marrow, and the presence of megakaryocytes and immature leukocytes in the capillaries of the lungs, liver, pulp of the spleen, and glomeruli of the kidneys.

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### Ringworm of the Scalp

During the past year there has been a tremendous increase in ringworm of the scalp in many parts of the country. To the best of our knowledge Ohio has been fortunate in not having had any severe outbreak of this disease, however there are definite reasons for believing it is on the increase.

Tinea capitis or ringworm of the scalp is commonly caused by one of a number of fungi. Heretofore the common causative agents in the cases occurring in the middle west were the fungi of animal origin. These cases usually respond favorably to local applications of fungicidal agents. A large proportion of cases in the recent outbreaks have been caused by a fungus of human origin known as *microsporum audouini*. Unfortunately these cases do not readily respond to local applications but are very recalcitrant to therapy. It is commonly necessary to produce epilation of the hair before a cure results. This is usually accomplished with X-ray and is a procedure only to be done by an expert as X-ray is always a potentially dangerous instrument.

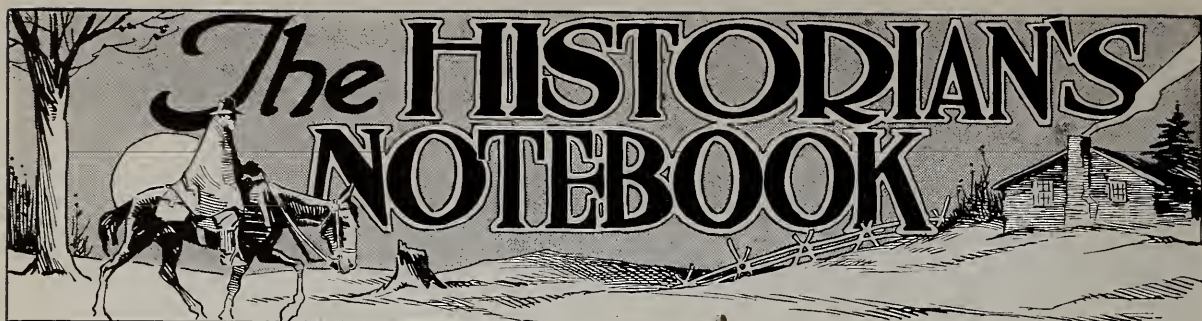
The diagnosis of tinea capitis can be established not only by finding the fungus and by clinical appearance, but also by showing the fluorescence of the fungus under the Wood's light. This instrument is of value also in determining cure. The fungus has been found on the backs of theatre seats by this means as well as on other objects contacting the scalps of infected children.

The Ohio Sanitary Code classifies ringworm of the scalp among the class "C" diseases, disabilities and infestations which are reportable only on occurrence in unusual prevalence.

So far as is known, the incidence of the disease has not yet reached serious proportions in Ohio, but physicians are urged to report cases to local health commissioners that the situation may be evaluated and precautions taken in the event of local outbreaks.

Health commissioners are urged to advise the Ohio Department of Health of cases of tinea capitis occurring in their health districts.

Roger E. Heering, M.D.,  
Ohio Director of Health.



*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## Historical Notes On the Northwestern Ohio Medical Association

JONATHAN FORMAN, M.D.

*(Continued from October, 1944, issue.)*

A SUMMER MEETING was held at Findlay, Ohio, on June 6, 1872. J. L. Reid, the Senior Vice President, presided. Some 31 physicians were nominated for membership. In the election H. D. Ballard was elected as President; J. W. Shoemaker and S. B. Hines, Vice Presidents.

One of the interesting tasks that the Society had to perform was the examination of Dr. L. S. Lafferty; Special committee having been appointed to investigate this physician's qualifications to practice, reported favorably, provided the gentleman would agree to complete the requisite course of lectures the coming Winter. The two papers that were presented were gun shot wounds of the knee joint and spinal irritation. Dr. B. B. Leonard then exhibited a number of calculi that had been extracted from the bladder itself.

The Winter meeting was held in Lima, December 4th. Dr. S. B. Hines in the chair. The Honorable James McKinzey delivered an address, giving much valuable information in relation to medical evidence. The Society was entertained at dinner by the Bar of Lima. Twelve new members were elected. The Essayist of the meeting was Dr. A. Hurd who read a long and interesting paper on the use and abuse of alcoholic stimulants in the treatment of disease. This provoked a lengthy and spirited discussion. Again, consideration was given to the feasibility of publishing the proceedings.

1873

The Summer meeting of 1873 was held at Van Wert, Ohio. The Senior Vice President, J. M. Shoemaker, in the chair. J. L. Price, Esq., read

Abstracted from the original minutes of the Northwestern Ohio Medical Association.

### *The Author*

● Dr. Forman is professor of the History of Medicine at Ohio State University, Columbus.

a paper on insanity and H. C. Gleen a paper on malpractice. The following morning the Association reconvened to transact its business and listen to the report of a case of cerebro spinal meningitis. Dr. W. H. Cole presented a paper on "Diet of Professional Hash". Dr. J. M. McCracken brought up the subject of milk sickness which was vigorously discussed by many of the members.

The Winter meeting was held in Toledo, Ohio, on December 3, 1873. Thirty-seven gentlemen were recommended and elected to membership. Dr. William Cherry read a paper on syphilitic corneitis. Dr. George A. Collamore read a paper on "Hydrate of Chloral", Dr. S. W. Skinner on "Cerebro Spinal Meningitis Epidemic". The following day Dr. A. Hurd of Findlay read a paper on "Puerperal Eclampsia". There was some discussion as to whether the meeting should be held in November and May of each year or whether there should be one annual meeting in June. Consideration of this had been compelled by the meetings of the states and national associations which were to be held in June, 1874. It was finally agreed to adjourn for one year with the time and place of meeting to be fixed by committee, so that the 11th meeting of the Northwestern Ohio Medical Association did not occur until one year later, namely, December 3, at Forest, Ohio.

Drs. Hine, Phillips and Shoemaker were appointed a committee to examine a Dr. Sams of



Tiffin as to his qualifications to practice medicine. Dr. Leonard read a paper on traumatic pneumonia. Dr. A. H. Phillips reported a case of congenital deformity of the esophagus and also a case of retained testicle which had been operated upon and removed. Dr. J. W. McCracken gave the history of the wound of the abdomen involving the peritoneum and permitting the intestines to protrude. The case recovered through the use of opium and rest. Dr. A. B. Rayton reported a similar case with recovery.

One of the honorary members was accused at this meeting of unprofessional conduct and a duly certified order or copy of an order bearing the seal of the State of Indiana discharging dishonorably the said gentleman from the United States service was read to the Society. His membership was withdrawn.

Dr. G. W. Galloway presented a case in propria persona of undulant ulcer of the leg and read a report of treatment and progress of the case thus far. Dr. A. Hurd read a report of a case of divided tendo-achillis with open wound successfully treated with complete union of the two ends. In the discussion Dr. Leonard said that he had treated a similar case in 1859.

Dr. Hurd offered the following: "In view of the fact that the so-called disease milk sickness generally prevails in the district represented by this association contradictory opinions of its true character, cause and pathology, I move that a committee of one from each committee represented in this association be appointed to collect, investigate and report at some future meeting of this association the relation to the etiology, pathology and treatment of the disease. (2) That said committee be authorized to issue printed circulars with questions to the profession generally in order to glean all the facts possible bearing upon the disease". This was carried and the committee appointed.

#### PROGRAM

Obstipation of the bowels successfully treated  
by Professor Mosler's method of irrigating  
the bowels with the fluid ..... Dr. A. Hurd

Typhoid Fever vs. Typho Malaria

Dr. J. N. Woods

Some of the diseases of Wood County

Dr. J. W. McCracken

Afflictions of the eye in smallpox

Prof. H. C. Scott

Phytolacea decandira and its use in mammitis

Dr. F. W. Fermin

#### SECOND DAY

A case of spontaneous or dry gangrene

Dr. S. B. Hines

Diseases of the throat ..... Dr. J. H. Williams

1875

The year was marked by a return to two meetings. The first one was held on the 19th of

May at St. Marys. The President, Dr. J. M. Hetzler, in the chair. Ten new members were elected. Among the order of business was the authorization of a seal for the Society. The retiring President gave his valedictory address on the subject of quackery and how to exterminate it. The business session brought forth several interesting resolutions. One was to the effect that the Society should be permanently located in Lima subject to removal only by a two-thirds vote of its membership, and another that "The Society as a body shall not ask alms of any railroad company, corporation, public or private society, nor of any person or persons not herein mentioned, nor of any member of this Society. Resolved that no member of this Society shall receive from any corporation, public or private, any indefinite sum for services rendered or to be rendered as railway passage, etc., or other indefinite sums for services rendered such as "no care, no pay" or treatment of families by the year for a stipulated sum, sick or well, nor shall any member of this Society take charge of the county poor in the capacity of physician or surgeon or any other charitable institution for sums less than those fixed by this Society in mileage or per day when in active service and, finally, resolved that the Society shall not extend its boundary lines beyond one congressional district."

Later on in the meeting Dr. W. W. Jones exhibited the advertising cards of F. W. Entriakin and J. A. Kinsman of Findlay and claimed that the letter and spirit of the code of the Association had been violated. When the resolutions stated above were brought forward for consideration a substitute resolution was submitted, namely, that the Society earnestly recommends the establishment of local town and county medical societies in the district occupied by this Association and that when so organized matters of local legislation (fees, prerequisites, ethics, etc.) be left entirely for the local Society and that for the present the jurisdiction and place of meeting be as heretofore. This was adopted unanimously.

#### PROGRAM

Prolapsus uteri with the report of several  
cases ..... G. W. Galloway

Practical surgery-hints on wounds ..... A. Hurd

Report of a case of thoracic aneurism

James A. Duncan

Dropsy of the aminon ..... Dr. Ishman of Cincinnati

Treatment of typhoid fever ..... J. N. Kinnard

Salicylic acid ..... U. A. Clark

A new uterus supporter ..... Dr. Bradley

In the evening a large audience of the professional citizens of St. Marys was addressed by Dr. T. A. Reamy of Cincinnati on the subject of a "Plea To and For the Medical Profession".

(To be continued.)

## The Doctor's Opportunity and Responsibility

—ARTICLE No. 1 OF A SERIES

**EDITOR'S NOTE:** The accompanying article was prepared by the Committee on Public Health Education of the Ohio State Medical Association by direction of The Council.

It is one of several articles which will appear in The Journal, addressed especially to physicians with the hope that they will elicit greater interest in the cancer problem and encourage the early diagnosis of malignant disease while it is still curable.

Publication of these articles is part of the Ohio State Medical Association's program of cooperation with the Ohio Field Army, American Cancer Society, in education of the public and members of the medical profession on the subject of cancer control.

The second article, which will appear in a future issue of The Journal, will deal with the office diagnosis of early cancer.

### THE DOCTOR IS ASKED:

If we succeed in teaching people the importance of prompt investigation of apparently trivial symptoms, it is obvious that with increasing frequency the physician will be consulted by people who do not have cancer.

In one experimental project designed to test the value of routine examination and prompt investigation of slight variations from normal good health, 1,103 women were examined with only 34 found to be suffering from cancer.

BUT another 267 were found to have benign tumors and 436 had some other disease or condition which required further investigation and care. Only 316, or less than 29 per cent, were reported as having "no pathology". Of the 34 cases of malignant disease discovered, the majority were sufficiently early to justify a high degree of optimism as to the results of therapy.

Included in this same experiment were 263 women who reported no symptoms. Of these, 50 were found to have benign tumors, 4 had malignant tumors and 15 had other diseases.

### THE DOCTOR'S OPPORTUNITY:

The cancer patient usually consults the family physician first. The opportunity—and the responsibility—for the discovery of early, curable cancer usually rests with the general practitioner.

The discovery of these early lesions, or the ruling out of cancer by the discovery of some other explanation for the patient's symptoms, gives the physician an opportunity to practice preventive medicine of the highest value and to demonstrate his competence to assume responsibility for the general well-being of his patients and of the community.

### THE DOCTOR'S RESPONSIBILITY:

The general practitioner who is asked by his patient "Do I have cancer?" is confronted with a grave responsibility. What can such a patient expect to receive from the physician in whom he has placed his confidence?

1. **A Sympathetic Hearing.** The patient who is concerned about the significance of some apparently trivial symptom or condition should not be dismissed lightly as a hypochondriac, a neurasthenic or the victim of cancer phobia.

The cure of cancer depends largely upon early diagnosis and prompt treatment. The symptoms of early cancer usually are just those vague indefinite aberrations which are so difficult of explanation. The patient without cancer or other constitutional or systemic disease should of course be reassured.

But the alert and conscientious physician will not offer such reassurance until he himself is assured that the patient's concern is without foundation. This assurance cannot be obtained without:

2. **A Careful History.** Since the evidence of early malignant disease is so frequently merely the evidence of some slight change in what has previously been normal for that particular patient, a carefully taken history can be of as much value in establishing a diagnosis as are physical examination and laboratory tests.

3. **A Thorough Examination.**

4. **Consultation When Needed.** The diagnosis of early malignant disease can seldom be accomplished on the basis of history and physical examination alone. Cancer which makes its own diagnosis is usually too far advanced to offer a favorable prognosis. Even the cancer specialist must depend upon the consultative help of such others as the pathologist, the roentgenologist, the practitioner in special fields of surgery.

The general practitioner should feel no hesitation in referring his patient to a specified consultant for the explanation of any doubtful symptom.



# Proceedings of The Council

## Vital Business Transacted at January 14 Meeting; Annual Meeting Cancelled; Policies Adopted on Important Questions Considered

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, January 14, 1945, with the following in attendance: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Rutledge, Lincke, Swan, Micklethwaite, Harding, and Knoble; Dr. Forman, Editor of *The Journal*; Executive Secretary Nelson and Assistant Executive Secretary Saville.

On motion by Dr. Knoble, seconded by Dr. Lincke, and carried, the minutes of the last meeting of The Council held on November 12, 1944, were approved.

The Executive Secretary reported that membership in the State Association as of January 13, 1945, totaled 4,684, of which 1,946 were military members; compared to a total membership of 6,878 on December 31, 1944.

On motion by Dr. Micklethwaite, seconded by Dr. Sherburne, and carried, The Council expressed sincere sympathy to Dr. Harry V. Paryzek, former President of this Association, and Mrs. Paryzek, whose son, Lt. Robert Paryzek, was killed in an airplane accident; and to Mrs. Geo. Edw. Follansbee, wife of Dr. Follansbee, who was a former president of this Association and for many years a member and chairman of the Judicial Council of the American Medical Association.

### 1945 ANNUAL MEETING CANCELLED

A communication from the Office of Defense Transportation, recommending that all meetings and conventions attended by more than fifty persons should be cancelled, providing cancellation would not impede the war effort, was read and discussed. On motion by Dr. LeFever, seconded by Dr. Knoble, and carried, The Council expressed a desire to cooperate 100 per cent in anything which would bring about an early termination of the war and authorized cancellation of the 1945 Annual Meeting of the Ohio State Medical Association, which had been scheduled for Columbus, May 1, 2 and 3. Commenting on this action, President Schriver emphasized that it would be more important than ever for all County Medical Societies to hold meetings with regularity.

### ACTION ON LEGISLATIVE PROPOSALS

The Executive Secretary reported on behalf of the Committee on Public Relations, which had

met in Columbus on Sunday, January 7. Recommendations of the committee were reviewed and The Council took the following action on matters considered:

A proposed bill to revise the State Poor Relief Law was approved in principle, providing changes suggested by the Committee on Public Relations are made in the proposal. Such changes involved the wording of sections defining medical care and hospital care and a section which would give the local relief authority the right to make special investigations as to whether additional medical and hospital care is necessary.

A proposal submitted in December, 1944, to the Ohio State Medical Association for review, providing for a serological test for syphilis on every pregnant woman unless such test is refused by such woman, was considered, together with a revised proposal submitted to the Association on January 6. The Council approved the original proposal in principle, providing one minor amendment is inserted. The Council refused to approve the revised proposal because of objections to several new sections which had been inserted.

### CHILDREN'S BUREAU ACTION PROTESTED

A communication was transmitted to The Council concerning a directive adopted by the Children's Bureau, U.S. Department of Labor, effective July 1, 1945, relating to the crippled children's program. The following statement of policy on this matter was adopted:

"It has been reported that the Children's Bureau, U.S. Department of Labor, has issued a directive having the force of law, effective July 1, 1945, withholding approval of any state plan for the care of crippled children that establishes any restriction as to race, color, creed, residence, economic status, or referral of the child to a clinic or hospital for diagnostic purposes by anyone other than the parents or guardian of a crippled child.

"The provisions of this directive, which would make it mandatory for a state to provide care for any crippled child regardless of economic status and for hospitals and clinics to accept a child for diagnostic examination solely on referral by the parents or guardian of the child, are in conflict with the policy of the Ohio State Medical Association.

"Only crippled children whose parents or guardians are unable to provide them with necessary care should be eligible to receive care under programs supported by public funds.

"A policy of permitting hospitals and clinics to accept children for diagnostic purposes without referral by a physician would place such institutions in the unlawful practice of medicine

and would be a violation of sound professional practices and medical principles.

"The Council of the Ohio State Medical Association is opposed to the provisions of the directive which have been cited. Such protest will be registered with the Children's Bureau.

"In event the directive is placed in force in Ohio without deletion of these provisions, The Council of the Ohio State Medical Association will urge the physicians of Ohio to withdraw from participation in the Ohio Crippled Children's Program. At the same time, however, The Council will urge Ohio physicians to continue to render necessary, competent care and treatment to all crippled children of this state so that no child will be denied proper care, on the understanding that such care would be provided under existing state laws relating to the medical care of the needy or by a physician on a private basis, with or without charge, depending on the economic status of the child, his parents or guardian."

#### TUBERCULOSIS PROGRAM ENDORSED

A program providing for an up-to-date tuberculosis control program in Ohio, drafted by the Advisory Committee on the Coordination of Tuberculosis Programs of the Ohio Public Health Association, was endorsed in principle.

A communication from a member of the Association pertaining to a provision in the uniform contract of the National Hospital Service Plans Commission (Blue Cross), relating to emergency room service, was considered. A recommendation of the committee that the Association communicate with the National Hospital Service Plans Commission as well as the American Medical Association, suggesting revision of the uniform contract in such a way that professional services would not be included in the emergency room service section of the contract, was approved. The committee had suggested that the wording of the national uniform contract follow the wording of contracts now in effect in several areas of Ohio, notably the Columbus area.

A communication from a Cleveland member, objecting to the provision of anesthesia services in the contract of the Cleveland Hospital Service Association (Blue Cross), was read and discussed. The Council approved the recommendation of the committee that the Ohio State Medical Association support the Cleveland Academy of Medicine in protesting inclusion of anesthesia services in the Cleveland Blue Cross contracts. The Council also approved the recommendation of the committee that, inasmuch as this is a local question, it is the responsibility of the Cleveland Academy of Medicine to obtain legal advice and to take any legal action which it may deem advisable.

A recommendation of the committee, that the Ohio State Medical Association reaffirm its previous policy in opposition to proposed legislation to exempt from the Medical Practice Act Christian Science practitioners and others claiming to

heal through the use of prayer or spiritual means, was approved.

A bill sponsored by the Ohio State Pharmaceutical Association before the Ohio General Assembly, providing for an increase in the membership of the Ohio Public Health Council from six to seven members and that the additional member shall be a registered pharmacist, was approved.

#### ENDORSE MENTAL HYGIENE PROGRAM

Recommendations of the Governor's Committee, for improvement in and expansion of mental hygiene services and facilities in Ohio, were approved, and the Governor's Committee congratulated on its excellent investigation and report.

A communication requesting the Ohio State Medical Association to support proposed legislation to permit the sale of colored margarine in Ohio and to repeal the present margarine tax was given thorough consideration. The Council concurred in the recommendations of the committee that the Association should not approve or disapprove such proposal for the reason that the question appears to be a clash between two commercial interests rather than a question primarily of public health.

A letter, requesting the Association to support proposed legislation making the enrichment of white flour and white bread with vitamins mandatory, was considered. The Council voted not to endorse such a proposal, believing that this is not the proper way to achieve the objectives, but that the proper method would be to encourage the producers to make flour and bread containing all of the natural vitamins and minerals and to educate the public of the desirability of natural, instead of artificially fortified, foods.

On motion by Dr. Knoble, seconded by Dr. Lincke, and carried, the above recommendations and actions of The Council were officially approved.

#### REGARDING INDEPENDENT ORGANIZATIONS

A number of communications from members and officials of county medical societies, requesting advice as to the policy and attitude of the Ohio State Medical Association concerning the Association of American Physicians and Surgeons, Gary, Indiana, were read and reviewed. The following statement of policy on this matter, covering other similar organizations organized independently of the American Medical Association and its constituent state and component medical societies, was adopted without a dissenting vote on motion by Dr. Sherburne, seconded by Dr. Harding, and carried:

"Several members of the Ohio State Medical Association have inquired as to the official policy of the Association regarding several organizations which have been organized independently of the American Medical Association and its constituent state and component local medical societies for the purpose of engaging in public



relations and legislative activities on behalf of the medical profession.

"Believing that the entire membership of this Association deserves a forthright answer to this question, The Council offers the following statement of policy and authorizes its publication in The Ohio State Medical Journal.

"The Ohio State Medical Association has not endorsed any such organization, either through action of the House of Delegates or by action of The Council, although the question has been before each for consideration on several different occasions.

"At the 1944 Annual Meeting of the Ohio State Medical Association, the House of Delegates adopted a resolution, reading in part as follows:

"That the Ohio State Medical Association express itself as believing that the American Medical Association is the proper organization to represent the medical profession of this country on legislative matters and questions pertaining to health and medical activities of all departments and agencies of the Federal Government, as well as similar activities of national unofficial and voluntary groups and organizations;

"That the Ohio State Medical Association pledges its active cooperation to the end that the potential strength of the American Medical Association shall be fully developed and instructs its delegates to the American Medical Association to support proposals which in their opinion would improve and strengthen the American Medical Association so it will be able to fully discharge its responsibilities and meet its obligations during the uncertain period which lies ahead."

"In 1943 the House of Delegates of the American Medical Association created a Council on Medical Service and Public Relations. Several of the purposes of this new agency are 'to investigate matters pertaining to the economic, social and similar aspects of medical care for all the people; to study and suggest means for the distribution of medical service to the public consistent with the principles adopted by the House of Delegates; to develop and assist committees on medical service and public relations originating within the constituent and component societies of the American Medical Association'.

"The Council on Medical Service and Public Relations has established an office in Washington with a full-time director and his staff. It has begun a program in line with the purposes creating it, including public relations, establishment of contacts with legislative and executive departments at Washington, and dissemination of information to the medical profession on legislative, economic and social developments affecting the practice of medicine and public health.

"When the question of endorsement of an independent organization was considered by the House of Delegates of the Ohio State Medical Association in 1944, the House of Delegates said that the question as to whether a physician should affiliate with and support such an organization must be decided individually by each physician.

"In the light of developments during the past several years and of pronouncements of the House of Delegates of the Ohio State Medical Association, previously cited, it is the considered opinion of The Council:

"That the American Medical Association is the proper organization to represent the medical profession on legislative, economic and social

questions of direct interest to the medical profession and to handle public relations for the medical profession, in cooperation with the constituent state and component county medical societies;

"That there is no necessity for the formation and maintenance of independent organizations to carry on these activities for the medical profession;

"That the present activities of the Council on Medical Service and Public Relations and other boards, councils, bureaus and committees of the American Medical Association, as well as of similar agencies of state and local medical societies, demonstrate that medical organization is capable of representing the medical profession;

"That medical organization is capable of carrying on many more productive activities for the benefit of the public and the medical profession alike if the profession will demand complete development of the potential resources, facilities and ability at the command of the American Medical Association and its state and local units, and will give its undivided support to all activities undertaken;

"That it is not the function of the Ohio State Medical Association to say to a member that he shall or shall not affiliate with or support any independent organization which may be soliciting his financial aid. This is a decision which each physician must make for himself. This Association is opposed to regimentation whether it be within or outside the ranks of the medical profession.

"However, it is entirely proper for the proper officials of this Association to provide members with information and advice on such matters, leaving it to the individual member to use his own good judgment as to the soundness and validity of such advice.

"That, finally, members of the medical profession, by concentrating their efforts on improving and strengthening their own national, state and local medical societies are more likely to achieve the goals of unity of purpose and effective action than by scattering their interest and efforts among the several independent organizations, now asking for their support, regardless of how worthy the purposes and motives of such organizations may be."

#### WASHINGTON DEVELOPMENTS

The Executive Secretary presented a report on new developments at Washington, pointing out that Congressman Dingell had re-introduced the so-called Wagner-Murray-Dingell Bill; that Senator Burton of Ohio, and Senator Hill of Alabama had introduced a proposal calling for the expenditure of approximately \$100,000,000 to assist states and local areas in increasing hospital facilities; and that Senator Pepper's Sub-Committee on Wartime Health and Education had recently issued an interim report, pursuant to Senate Resolution 74 and following extensive hearings started in July, 1944.

#### WORKMEN'S COMPENSATION MATTERS

A report from Dr. Hein, chairman of the Committee on Workmen's Compensation, was presented by the Executive Secretary. The Council, on motion by Dr. Sherburne, seconded by Dr. Swartz, and carried, approved certain recommen-



dations of the committee with respect to changes suggested by the Industrial Commission in the proposed revised medical and surgical fee schedule presented to the Commission by the Association several months ago. It was reported that Dr. Hein and a sub-committee of his committee are planning an early conference with the Commission in an effort to arrive at mutually satisfactory agreements on certain portions of the Association's recommendations.

#### MEDICAL SERVICE PLAN

At this point Dr. Robert C. Rothenberg, Cincinnati, chairman of the Committee on Medical Service Plans, appeared before The Council. He reported that his committee had held meetings on Saturday night, January 6, and on Sunday, January 7, and that considerable progress is being made in working out legal and other matters in connection with the formation of a stock medical indemnity company to operate in co-operation with the Blue Cross Plans of Ohio.

A recommendation of the committee, that the Association employ a full-time man to handle details for the committee in connection with the organization of the company, was approved, on motion by Dr. McNamee, seconded by Dr. LeFever, and carried.

On motion by Dr. Sherburne, seconded by Dr. Swartz, and carried, The Council authorized the President to increase the size of the committee at his discretion.

The Council expressed sincere appreciation to the committee for its fine work to date and for the large amount of time and effort expended by the committee on this important project.

#### MISCELLANEOUS TRANSACTIONS

A set of proposed amendments to the Constitution and By-Laws of the Woman's Auxiliary of the Ohio State Medical Association, presented to The Council for review and approval, was referred to the Woman's Auxiliary Advisory Committee for consideration.

Dr. Roger E. Heering, who was recently appointed State Director of Health, present on invitation of President Schriver, was introduced to The Council. Following an informal discussion, The Council voted Dr. Heering its cooperation and requested him to call upon it for assistance at any time.

Prior to adjourning, The Council adopted a resolution presented by Dr. Harding and Dr. Micklethwaite congratulating Dr. Charles A. Doan, chairman of the Committee on Scientific Work, on his appointment to the deanship of the Ohio State University College of Medicine and offered to Dr. Doan the active assistance and co-operation of the Ohio State Medical Association.

Attest: CHARLES S. NELSON,  
*Executive Secretary.*

### Ohio Hospitals Approved by American College of Surgeons

The American College of Surgeons has approved 231 hospitals in the United States and Canada for graduate training in general surgery and the surgical specialties.

Dr. Malcolm T. MacEachern, associate director, states that 500 or more surveys of hospitals offering opportunities for graduate training in surgery are planned during the coming year, the increased emphasis upon this work being stimulated by the need for providing ample opportunities for resumption of training by medical officers when they return from service with the armed forces.

A list of the Ohio hospitals approved by the A.C.S. for such training follows:

| Name of Hospital and Location               | Bed Capacity | Approved for Graduate Training In                                                            |
|---------------------------------------------|--------------|----------------------------------------------------------------------------------------------|
| <b>Akron—</b>                               |              |                                                                                              |
| City Hospital.....                          | 373          | General Surgery                                                                              |
| <b>Cincinnati—</b>                          |              |                                                                                              |
| Children's Hospital...                      | 208          | General Surgery                                                                              |
| Christ Hospital.....                        | 325          | General Surgery                                                                              |
| Cincinnati Gen. Hosp.                       | 900          | General Surgery<br>Orthopedic Surgery<br>Obstetrics<br>Ophthalmology<br>Otolaryngology       |
| Good Samaritan Hosp..                       | 539          | General Surgery                                                                              |
| <b>Cleveland—</b>                           |              |                                                                                              |
| Babies and Children's Hospital <sup>1</sup> |              |                                                                                              |
| City Hospital.....                          | 1588         | General Surgery<br>General Surgery (Thoracic)<br>Obstetrics and Gynecology<br>Otolaryngology |
| Cleveland Clinic Foundation Hospital....    | 250          | General Surgery<br>Neurological Surgery<br>Orthopedic Surgery<br>Urology                     |
| Lakeside Hospital <sup>1</sup>              |              |                                                                                              |
| MacDonald House <sup>1</sup>                |              |                                                                                              |
| Mount Sinai Hospital.                       | 225          | General Surgery                                                                              |
| St. Alexis Hospital....                     | 220          | General Surgery                                                                              |
| St. Luke's Hospital....                     | 388          | General Surgery<br>Obstetrics and Gynecology<br>Ophthalmology<br>Otolaryngology              |
| St. Vincent's Charity Hospital .....        | 290          | General Surgery                                                                              |
| Univ. Hosps. of Cleveland .....             | 692          | General Surgery                                                                              |
| Babies and Children's Hospital 141          |              | Orthopedic Surgery<br>Urology                                                                |
| Lakeside Hosp... 405                        |              |                                                                                              |
| MacDonald House .....                       | 146          | Obstetrics and Gynecology<br>Ophthalmology<br>Otolaryngology                                 |
| <b>Columbus—</b>                            |              |                                                                                              |
| Starling Loving University Hosp.....        | 267          | General Surgery<br>General Surgery (Thoracic)<br>Urology<br>Gynecology                       |
| <b>East Cleveland—</b>                      |              |                                                                                              |
| Huron Road Hosp.....                        | 271          | General Surgery<br>Obstetrics and Gynecology                                                 |
| <b>Toledo—</b>                              |              |                                                                                              |
| St. Vincent's Hosp....                      | 330          | General Surgery<br>Orthopedic Surgery<br>Urology<br>Obstetrics and Gynecology                |

<sup>1</sup>See University Hospitals of Cleveland.



# Teamwork for the Critical Months Ahead

## A Message to the Physicians of Ohio From Dr. Robert Conard, Chairman, Procurement and Assignment Committee

**A**FTER more than three years of war the medical profession of Ohio may profit by a look at its record.

Of approximately 9,000 active physicians in the state at the beginning of the war about 3,100 are now in uniform.

For these dispersed over all the continents and islands and on the seven seas we feel deep pride in their record of duty well done; and for those who have given their lives, sorrow and humble gratitude for their sacrifice.

In all theaters of war our men are playing a major role. They are writing new and brilliant pages of medico-military history. The full story we will not know until long after their return to the way of peace.

### DEATHS TELL A STORY

There are others who also serve. There are the older men, far beyond military age, who have shouldered the burden the younger men left at home and grimly carry on despite handicaps of age and infirmities which in normal times would be ample reason to seek a life of ease.

The necrology pages of this *Journal* tell the story of the fatalities in this section of our rank and file.

It is the hard task of the Procurement and Assignment Service which, in this state, is our War Participation Committee, to try to keep the balance between civilian and military need for medical service.

To do this it has been necessary to deny to a considerable group of doctors of military age the privilege of serving with the colors despite their expressed desire to do so. These men, for the most part living and working in rural communities are in many instances acutely unhappy, feeling that they are looked upon as shirking service.

Quite aside from the fact that most of these men are doing many times a normal day's work every day, giving service urgently needed in the care of the civilian population, their lot is far from a happy one. Medical schools, war industry and research claim the services of a comparatively small group of men eligible for military service for whom trained replacements could not be found.

So much on the credit side. Candor compels us to make it clear that there is a less pleasing side to the picture.

Two hundred and twenty-seven physicians of military age in Ohio are now on our available

list. By the considered judgment of their local colleagues they can be spared from civilian service and are available for military duty. With few exceptions, these physicians repeatedly have been invited by the Officer Procurement Service of the Army, or Navy, or both to apply for a commission and have declined to take any action.

These men who have declined to volunteer are well known to their colleagues and neighbors. When one contrasts this attitude with that of those who are playing a manful part in this war, one must give thought to the effect upon the future professional standing of these men, in the opinion of their fellows and of the public.

In attempting to maintain a balance of at least minimum adequate medical service to the people at home, as has been pointed out, certain physicians have been held to be essential to the service of certain communities.

### SHOULD NOT CHANGE AREAS

The work is hard, the hours long, rest and recreation rare. Perhaps a flattering offer for a fellowship, a salaried position, or a more attractive location presents itself. The temptation is great to pick up and leave for some one or the other of these more attractive and less arduous fields.

While in no sense does the Procurement and Assignment Service have, nor wish to have, any compulsory authority or power to compel a physician to go or to stay, it is an important part of the plan by which things are kept in balance that every man rated essential stick to his post and do his part to keep our voluntary system of distribution of medical care working as efficiently as can be under the present hard conditions.

Continually our calculations and estimates of need are being upset by death or disability among the younger as well as the older men.

If every man plays his part, we can come through the increasingly critical months ahead without serious shortages that can now be foreseen.

The medical profession of Ohio is still a strong team, though a third of its best men are playing in a more deadly game.

**Don't Let The Team Down!**

—Robert Conard, M.D., Wilmington, Ohio,  
Chairman, Ohio Procurement and  
Assignment Committee for Physicians.

# National Authority on Management of Gonorrhea To Speak at Meetings Arranged by O.S.M.A. and Local Societies

**O**HIO physicians will have an opportunity the last week in February and the first two weeks in March to hear one of the outstanding urologists of the country, Dr. P. S. Pelouze, Philadelphia, speak on the subject, "Diagnosis and Management of Gonorrhea", with special emphasis on recent progress in diagnosis and therapy and with particular reference to the use of penicillin.

Dr. Pelouze will speak at 11 centers in Ohio under the joint auspices of the Ohio State Medical Association, the County Medical Societies of the 11 meeting places, and the Ohio Department of Health.

Physicians, nurses and health officials are cordially invited to hear Dr. Pelouze at the meeting closest to their place of residence. A schedule of the places and times of these meetings is appended. Special announcements will be mailed to members in the various areas at a later date.

## ASSISTANT PROFESSOR OF UROLOGY

Dr. Pelouze is assistant professor of urology, University of Pennsylvania; honorary president of the American Neisserian Medical Society; special consultant to the United States Public Health Service; and the author of the following books: "Gonorrhea in the Male", "Gonorrhea in the Male and Female", now in its third edition, and "Office Urology".

The Ohio State Medical Association considers itself fortunate in being able to cooperate with the Ohio Department of Health and the 11 county medical societies selected, in sponsoring this address by such an outstanding authority on venereal diseases.

## SCHEDULE OF MEETINGS

The schedule of meetings, including place, time and counties in each area, follows:

### Tuesday, February 27

**LIMA**—Nurses' Auditorium, Lima Memorial Hospital, 8:30 P.M.; sponsored by Academy of Medicine of Lima and Allen County; physicians from following counties urged to attend: Allen, Paulding, Putnam, Van Wert, Mercer, Auglaize, Hancock, Hardin and Logan.

### Wednesday, February 28

**PIQUA**—Public Assembly Room, Piqua National Bank, 8:30 P.M.; sponsored by Miami County Medical Society; physicians from following counties urged to attend: Miami, Montgomery, Shelby, Darke, Champaign, Clarke, Greene, Preble, Butler, Warren and Clinton.

### Thursday, March 1

**PORTSMOUTH**—Nurses' Home, Portsmouth General Hospital, 8:30 P.M.; sponsored by the Hempstead Academy of Medicine; physicians from following counties urged to attend: Seiote, Brown, Adams, Pike, Ross, Jackson, Vinton, Lawrence, Gallia and Meigs.

### Friday, March 2

**MARIETTA**—Marietta Memorial Hospital, 8:30 P.M.; sponsored by the Washington County Medical Society; physicians from the following counties urged to attend: Washington, Athens, Noble and Monroe.

### Monday, March 5

**ZANESVILLE**—Zane Hotel, Zanesville, 8:30 P.M.; sponsored by the Muskingum County Academy of Medicine; physicians from the following counties urged to attend: Muskingum, Licking, Perry, Morgan, Guernsey and Coshocton.

### Tuesday, March 6

**AKRON**—Nurses' Home, Akron City Hospital, 8:30 P.M.; sponsored by the Summit County Medical Society; physicians from the following counties urged to attend: Summit, Portage and Medina.

### Thursday, March 8

**CANTON**—School of Nursing, Mercy Hospital, 9:00 P.M.; sponsored by the Stark County Medical Society; physicians from the following counties urged to attend: Stark, Carroll, Tuscarawas and Wayne.

### Friday, March 9

**STEUBENVILLE**—Ohio Valley Hospital, 8:30 P.M.; sponsored by the Jefferson County Medical Society; physicians from the following counties urged to attend: Jefferson, Harrison and Belmont.

### Tuesday, March 13

**MANSFIELD**—Mansfield General Hospital, 8:30 P.M.; sponsored by the Richland County Medical Society; physicians from the following counties urged to attend: Richland, Ashland, Holmes and Knox.

### Wednesday, March 14

**MARION**—Hotel Harding, 8:30 P.M.; sponsored by the Marion Academy of Medicine; physicians from the following counties urged to attend: Marion, Seneca, Crawford, Wyandot and Morrow.

### Thursday, March 15

**COLUMBUS**—Columbus Gallery of Fine Arts, 8:30 P.M.; sponsored by the Columbus Academy of Medicine; physicians from the following counties urged to attend: Franklin, Delaware, Union, Madison, Fayette, Pickaway, Fairfield and Hocking.

## Ruling on Blue Cross Contract

A subscriber to a Blue Cross plan who enters a non-profit hospital which is not participating in the plan is entitled to the same benefits there, as if he had chosen a participating hospital, according to Opinion No. 7311, rendered Dec. 23, 1944, by Attorney General Thomas J. Herbert. Syllabus of the opinion follows:

"Where a subscriber to a service plan contract issued by a hospital service corporation elects to enter a non-participating non-profit hospital in the state of Ohio, he is entitled to receive the same benefits under his service contract as if he had chosen a participating hospital, and a provision in the service plan contract providing different benefits for a subscriber who so elects to enter a non-participating hospital than for those who enter participating hospitals is invalid as being in conflict with Sec. 669-4, G.C."



## Ohio State Medical Association's 1945 Annual Meeting Cancelled; A.M.A. Meetings Also Called Off

**B**Y action of The Council on January 14, the Ninety-Ninth Annual Meeting, which had been scheduled for Columbus, May 1, 2 and 3, 1945, has been cancelled.

This action was taken pursuant to a request issued by the Office of Defense Transportation to all organizations that meetings attended by more than 50 persons be cancelled unless the cancellation of the meeting would impede the war effort.

To substantiate its request, the O.D.T. cited the critical transportation situation and serious congestion of hotels, restaurants, etc., especially in metropolitan areas.

It was the sense of The Council that the Association should cooperate fully with the government on any matters which would hasten the termination of the war and that the holding of the Annual Meeting would not be of direct importance to the war effort.

In taking this action The Council emphasized that it will be more important than ever for all County Medical Societies to hold meetings regularly for the purpose of providing members with talks on medical advances and for a discussion of legislative, economic and social questions of vital importance to physicians.

All officers, Councilors and committeemen of the State Association will continue in office for another year as a result of cancellation of the 1945 meeting.

Official announcement has been made by the American Medical Association that the 1945 Annual Session of the A.M.A., scheduled for Philadelphia, June 18-21, has been cancelled. Information has been received that the New York State Medical Society annual meeting has been cancelled. Cancellation of other society meetings scheduled for the Spring and Summer is anticipated. According to the Columbus Convention Bureau, many organizations which had planned to hold meetings in Columbus during the next four or five months have called off their meetings.

Under date of January 19, the American Medical Association announced the cancellation of the Seventh Annual Congress on Industrial Health and the Annual Congress on Medical Education, scheduled for Chicago the week of February 11.

Complying with the O.D.T. request, the National Conference on Medical Service, which had been scheduled for February 11, at Chicago, also has been cancelled.

## Dr. Roger E. Heering, Experienced Public Health Service Officer, Appointed State Director of Health

**D**R. ROGER E. HEERING, Columbus, venereal disease control officer of the Ohio Department of Health since March, 1943, was appointed State Director of Health on January 2 by Governor John W.



DR. HEERING

Bricker from a list of nominees submitted by the Ohio Public Health Council. His term of office extends to January 1, 1950. His appointment has been confirmed by the State Senate.

Well qualified by training and experience to direct the State's public health program, Dr. Heering, who is 34 years of age, graduated at the University of Michigan Medical School in 1933, following which he served general rotating internships at the U. S. Marine Hospital and Grant Hospital, Chicago. In December, 1934, he was commissioned as Assistant Surgeon, United States Public Health Service, and assigned to the medical staff of the U. S. Employees' Compensation Commission, Washington, D. C.

After 18 months on that duty, Dr. Heering was transferred to the U. S. Marine Hospital,

Norfolk, Va., and assigned to the venereal disease service. During that assignment he had three and one-half months' temporary duty with the U. S. Coast Guard, as medical officer on the U.S.C.G. cutter, Mendota, on ice patrol in the North Atlantic. Dr. Heering was promoted to the grade of Passed Assistant Surgeon in December, 1937.

Beginning in July, 1938, Dr. Heering spent a year at the Johns Hopkins School of Public Health and Hygiene, and in June, 1939, was awarded the degree of Master of Public Health. During that year he devoted about half of his time to work in the syphilis clinic under Dr. J. E. Moore.

Dr. Heering's next assignment was venereal disease control officer in the Cincinnati Health Department under Dr. Carl A. Wilzbach, health commissioner, beginning in June, 1939. After nearly two years there, he was appointed venereal disease consultant for U. S. Public Health Service, District No. 1, with headquarters in New York City. The district comprised 10 states from Maine to Delaware.

In March, 1943, Dr. Heering was assigned to the Ohio Department of Health, as venereal disease control officer. He was promoted to the grade of Surgeon, April 1, 1943. Dr. Heering is a Fellow of the American Medical Association and a member of the American Neisserian Medical Society.

**Zanesville**—Dr. Beatrice T. Hagen was reappointed health commissioner of Muskingum County, a post which she has held for the past 15 years.

**Findlay**—Dr. Frederick C. Smith, Marion, congressman for the Eighth Ohio Congressional District, analyzed the Murray-Wagner-Dingell bill and urged its defeat at a meeting of the local Kiwanis Club. Radio station WFIN broadcast the address. Dr. O. P. Klotz introduced the speaker.

**Lancaster**—"The Present Status of Planning for the Extension of Health and Medical Services", was the topic discussed by Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, at a meeting of the local Kiwanis Club.

**Washington, C.H.**—Reasons why the public should oppose socialized medicine were presented by Dr. Jonathan Forman, Columbus, at a meeting of the local Rotary Club.

**Middletown**—"The medical profession has shown more progress in the past 44 years than it did in the preceding 500 years", Dr. Ross A. Hill told Kiwanians at a meeting recently.

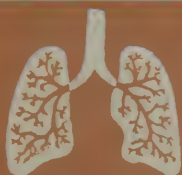
**Urbana**—A hospital association has been organized to undertake the task of raising \$300,000 through public subscription over a three-year period, for the purpose of establishing a new 50-bed hospital.

**Columbus**—Dr. Frank F. Tallman, State Commissioner of Medical Diseases, spoke on "Fear", at a meeting of the Fireside Club of the First Congregational Church. He also recently addressed the first annual meeting of the Cleveland Mental Hygiene Association on the subject: "Better Mental Health for Ohio Citizens".

**Columbus**—Dr. J. P. Turner, with the U.S. Public Health Service in New Orleans, has been transferred here to become a full-time venereal disease control officer with the city department of health.



## OF TRIPLE ADVANTAGE IN MYOCARDIAL DECOMPENSATION

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1. Sperling, L., Weisman, S. and Papermaster, R.: Surgery, 11:600-604 (April) 1942.
2. Boyer, N. H.: J.A.M.A., 122:306-309 (May 29) 1943.
3. McMahon, A. and Nussbaum, R. A.: So. Med. J., 33:1127 (Nov.) 1940.

\*Contains at least 80% anhydrous theophyllin.

**SEARLE**

RESEARCH IN THE SERVICE OF MEDICINE

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# A.M.A. Activities:

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Digest of News on the Current Projects,  
Programs and Services Which Are Being  
Carried on by Your National Society

THE twelfth consecutive season of nationwide network health broadcasts presented by the American Medical Association and the National Broadcasting Company began January 6 and will continue through June 30. The programs will be broadcast each Saturday at 3 P.M., Central War Time. The title for the 1945 series is "Doctors Look Ahead". Broadcasts will relate to wartime and postwar developments, with special emphasis on medical progress of the present day and what it foreshadows for the nation's health in the immediate future. Dr. W. W. Bauer, director of the Bureau of Health Education of the A.M.A., will summarize each program, except where other speakers are announced. The series is being broadcast in Ohio by the following NBC stations: WTAM, Cleveland; WLOK, Lima; and WHIZ, Zanesville. The Ohio stations to which the program is available, but which are not carrying it, are: WLW and WSAI, Cincinnati and WSPD, Toledo.

\* \* \*

Thomas A. Hendricks, Executive Secretary of the Indiana State Medical Society, has been loaned to the Council on Medical Service and Public Relations of the A.M.A., as part-time consultant.

\* \* \*

According to Lt. Col. Harold C. Lueth, M.C., A.U.S., who has been placed in charge of the new Bureau of Information at the A.M.A. headquarters, Chicago, the specific aims of the bureau fall into three categories, namely: To provide veteran medical officers with information concerning educational opportunities immediately after their term of military service; to provide the medical officer with information concerning state licensure and facilitate their procurement of licensure in states other than the state of former practice or licensure; to provide the medical officer with information concerning medical, social, economic, financial and other phases of community life that will enable him to make a wise selection of a permanent location in which to practice medicine. A comprehensive article on the Bureau was published in the January 6 issue of *The Journal of the A.M.A.*, page 33.

\* \* \*

The Board of Trustees of the A.M.A. has approved in principle a draft of a proposed uniform state law relating to chemical tests for intoxication in traffic accidents involving an alleged drunken driver. Scientific standards incorporated in the proposal were recommended by the A.M.A. Committee to Study Problems of Motor Vehicle Accidents.

\* \* \*

Complete text of the Interim Report of the Subcommittee on Wartime Health and Education (headed by Senator Pepper, Florida) of the U.S. Senate Committee on Education and Labor, issued early in January, was published in the January 6 issue of *The Journal of the A.M.A.*, page 36. It should be read by every physician, as it makes recommendations for a huge Federal medical, health and hospital program.

\* \* \*

A dozen or more vital questions on postwar medical services and postwar medical education were considered by the Committee on Postwar Medical Service of the A.M.A. in session December 9. A complete digest of the transactions of the meeting was published in the January 13, 1945, issue of *The Journal of the A.M.A.*, pages 107-108. This is "must" reading.

\* \* \*

The Council on Medical Service and Public Relations has issued a statement that the American Medical Association is on record in favor of both indemnity and service types of prepayment medical care plans which meet the essentials laid down by the House of Delegates, not just indemnity type of plans which is the view held by some misinformed persons.

\* \* \*

A list of approved schools for training X-ray technicians, meeting the essentials laid down by the House of Delegates of the A.M.A., has been compiled by the Council on Medical Education and Hospitals. (January 13, 1945, issue, *The Journal of the A.M.A.*) Additional training programs will be added to the list when it has been determined they meet the essentials.





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# Provisions of U. S. Income Tax Law of Special Interest To Physicians; Suggestions on Deductions, Forms, Etc.

**U**NDER the provisions of the Individual Income Tax of 1944, every person whose 1944 gross income was \$500 or more, must, not later than March 15, 1945, file certain returns with the District Collector of Internal Revenue for the district in which the taxpayer resides.

While the new act simplifies some of the requirements, it does not affect materially the problem of the individual physician in determining his net income for income tax purposes. *The Journal* urges every physician to obtain advice and assistance from competent legal or tax authorities or staff members in the offices of the District Collectors of Internal Revenue. With the high rates and possible penalties involved, it is most important that every physician be certain that his income tax returns are prepared accurately and carefully.

Based on information obtained from Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for 11th Ohio Internal Revenue District, *The Journal* presents the following high spots of the income tax law, with an explanation of the items which physicians in private practice can properly deduct as business expense from gross income.

## FORMS AND PAYMENTS

Not later than March 15, 1945, every physician who comes within the provisions of the Income Tax Law, must do the following:

1. File an actual return, on Form 1040, for 1944.

2. Pay the difference, if any, between the income tax paid during 1944, based on the estimated return for 1944 which he filed during that year, and the amount of the tax computed on his final return for 1944 filed on or before March 15, 1945. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry interest at six per cent from March 15, 1945, to date of payment.

3. Pay the deferred balance of the unforgiven portion of his 1942 or 1943 tax as reflected by his 1943 return. A separate statement of this amount will be mailed to each taxpayer by the district collector, and separate payment must be made. Over-payment credits can not be applied to this account.

4. File a declaration of estimated tax for the year 1945, and pay one-fourth of the estimated tax for 1945, the balance payable quarterly thereafter. Blanks for filing the 1945 return have been mailed to taxpayers of record by the district collectors of internal revenue. If estimated re-

turns for 1945 are based on 1944 income and the tax computed at 1945 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

## THOSE PAID A SALARY

Any individual whose earnings are subject to withholding, e.g., a physician in a salaried position, and whose earnings are not in excess of \$5,000, may elect to make a return simply by supplying the information required on the withholding receipt furnished by his employer, W-2, (rev.), and forwarding the original copy to the office of the district collector. The tax will be computed and any amount due over the withholding will be assessed against the taxpayer, or if the withholding is in excess of the actual tax due, a refund of the over-payment will be made.

## REPORT ON FUNDS PAID

While it is not necessary this year to report salaries of office assistants and other employees whose salaries are subject to the withholding tax, as in previous years payments in excess of \$500 made during 1944 for interest, rents or commissions, not subject to withholding and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1945, to the Commissioner of Internal Revenue, Sorting Section, Washington, D.C.

## DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

**For the Columbus District (Ohio 11th)** Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus, comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

**For the Cleveland District (Ohio 18th)** Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

**For the Cincinnati District (Ohio 1st)** Collector of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:



Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami Montgomery, Preble and Warren.

**For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo;** comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

#### THOSE IN MILITARY SERVICE

A physician who is on active military duty should file his income tax return in the office of the Collector of Internal Revenue of the district in which he was a legal resident immediately prior to his entrance into active service. Compensation received for military service is subject to income tax.

Members of the armed forces who are on duty outside the continental limits of the United States are not required to file a return until the 15th day of the third month following their return to this country.

Men in the service are permitted a deduction of \$1,500 from gross income, in addition to the usual personal exemption and the credit for dependents.

#### DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted by a physician from gross income:

**Office Rental**—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he can not claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

**Automobile**—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician

possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

**Professional Dues**—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held not to be deductible.

**Traveling Expenses**—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

**Salaries and Wages**—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

**Medicines, Supplies, Etc.**—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals, and other supplies "consumed in the using" and necessary to operate the office may be deducted.

**Equipment, Furniture, Library, Etc.**—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

**General Office Expenses**—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

**Debts**—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using this latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

**Taxes and Licenses**—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholders of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible.

**Sales Tax payments may be deducted.** A reasonable allowance will be permitted in proportion to the physician's income. Should the claimed exemption appear too large, however, the burden of proof falls upon the taxpayer, and he may be called upon to produce purchase receipts to substantiate his claim. Sales tax coupons are not considered sufficient evidence.

**The Ohio Gasoline Tax** is deductible to the extent of four cents per gallon. If a physician has already deducted the cost of gasoline used in making professional calls as automobile expense, he can not of course make an additional deduction of four cents per gallon for gasoline so used. However, he may deduct that amount on gasoline purchased for other than professional use.

All license fees which the physician is required to pay are deductible, including the narcotic tax, automobile license tag fee, local occupational taxes, taxes on club dues, etc.

Under the 1944 Income Tax Act, such Federal taxes as the auto use tax, amusement taxes, and taxes on club dues and long distance telephone

tolls are no longer deductible items. However, deductions may be made for taxes on telephone tolls covering calls for business or professional purposes, and which calls are in themselves deductible as business expense.

**Federal Old Age Benefits and Unemployment Compensation Taxes** paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible on returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. However, Federal Old Age Benefits payroll deductions from employees' wages are not proper deductions from individual Federal income tax returns. The reason for this latter distinction is that the individual employee at a future date will have returned to him in the form of pensions the money which is deducted from his current wages.

**Interest**—amounts paid out as interest upon indebtedness (except interest paid to carry non-taxable securities) are deductible.

**Losses by Fire and Theft**—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair is claimed as a deduction.

**Insurance Premiums**—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

**Legal Expenses**—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible.

**Contributions, Gifts, Etc.**—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the adjusted gross income.

**Optional Standard Deduction**—Under the 1944 law a taxpayer may elect in lieu of listing ordi-



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**A**CCCEPTANCE OF any product by the Council on Pharmacy and Chemistry of the American Medical Association is always a source of gratification.

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Feinberg (1), in reviewing the subject, states: "There is good indication that the antigen of house dust more recently isolated by Boatner and her associates is capable of producing marked reactions on scratch test and is more useful in serving to determine true dust allergy".

Factors contributing to the uniformity and specificity of these products are the unique manner of collecting and processing the source material. This gives them universal application regardless of variation in local dusts.

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Available, in various concentrations, in the Diagnostic Set Package . . . Treatment Set Package . . . Bulk Treatment Package.

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\*Prepared, under exclusive license, by Boatner-Efron process, U. S. Patent No. 2,316,311.

(1) Feinberg, S. L., Allergy in Practice, Chicago, Year Book Publishers, 1943, 293.

**ENDO PRODUCTS INC.** RICHMOND HILL, 18  
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nary deductions such as contributions, interest and taxes, to take advantage of the optional deduction of 10 per cent of his adjusted gross income, up to a total of \$500. If the adjusted gross income is less than \$5,000, and the taxpayer elects to take the optional standard deduction, the amount of the tax will be found on the table on Page 2 of income tax return Form 1040.

**Medical and Dental Expenses.**—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of 5 per cent of the taxpayer's adjusted gross income. In the case of a husband and wife the expenses are not deductible unless they exceed 5 per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return or the return of a head of a family is \$2,500, and for a single person, \$1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

A special deduction of \$500 is allowable to a taxpayer who is blind.

### Ohio Personal Property Tax

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31, annually.

All tangible and intangible personal property (not real property) in possession of a physician on January 1, 1945, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

Such returns should be made in duplicate. The so-called intangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which

are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the **Actual Value** of his current accounts receivable—the amount that probably can be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1944 return he would be permitted to return as of "no value" accounts receivable which he listed in 1943 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1943 but which have decreased in actual value during the past year.

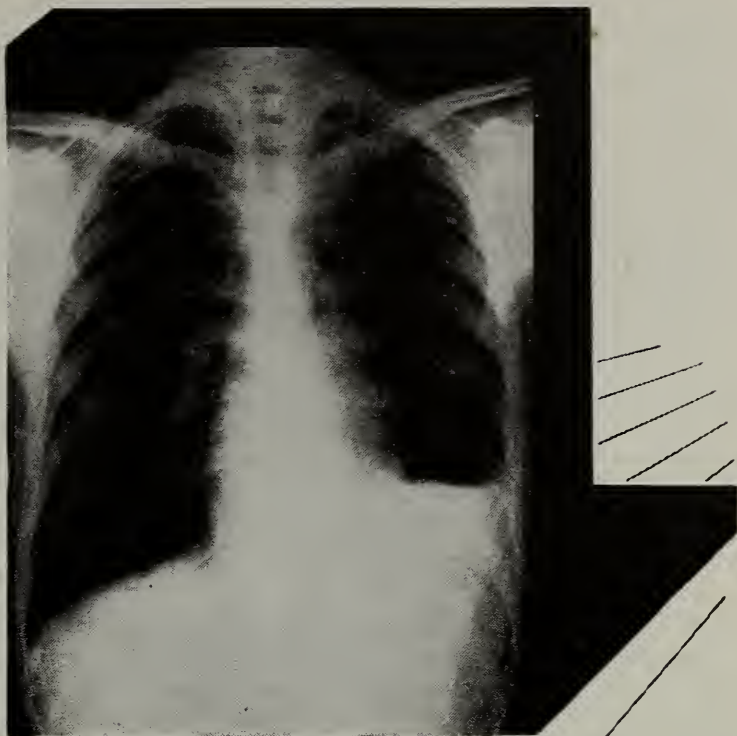
### Old Age Benefits Tax

The Old Age Benefits Tax is payable by every physician who employs one or more persons in his office. It amounts to one per cent on the first \$3,000 of each employee's wage paid by the employer and a like amount deducted from the wages of each employee. The tax return and informational return, combined in one report, Form SS-1-A, is to be filed **quarterly**. The tax must be paid and the return filed prior to April 30, 1945, for the months of January, February and March, 1945, in the office of the District Collector of Internal Revenue, and quarterly thereafter.

### Unemployment Compensation Tax

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report," and Form BUC-75 report of





# **PENICILLIN** Creates New Concepts Sterilizing an Empyema

Penicillin shatters old concepts and is rapidly creating many new ones. This applies particularly to the treatment of empyema. It has been demonstrated that penicillin will usually sterilize the pleural exudate, provided the infecting organism is penicillin sensitive. A significant number of patients with pneumococcic, streptococcic, and staphylococcic empyema were improved or recovered after repeated aspiration of the

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Penicillin (Upjohn) is supplied in vials containing 100,000 Oxford units.

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individual worker's wages, quarterly with the Ohio Bureau of Unemployment Compensation, Columbus. Report for the period of October 1 to December 31, 1944, was due January 31, 1945. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating.

Employers of eight or more persons, under the Federal Unemployment Compensation Law, must have filed with the District Collector of Internal Revenue on Form No. 940, prior to January 31, 1945, a report of wages paid during 1944. The tax is 3 per cent, less a credit of the amount paid to the Ohio Bureau of Unemployment Compensation. In other words, 90 per cent of the Unemployment Compensation Tax of employers of eight or more persons will be paid to the State and 10 per cent to the Federal Government.

### Ohio Use Tax

The Ohio Use Tax Law, passed in 1936, supplementing the Retail Sales Tax Law, imposes a tax on the same basis as the sales tax, on purchases made outside the state. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the State Tax Commission to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Commission. However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Commission, he is required to report such purchases to the Tax Commission and pay the tax. Returns must be filed with the Commission by April 15, 1945, for purchases during the period January 1 to March 31, 1945, and quarterly thereafter.

## Do You Know . . .

Harry C. Eader, chief of the audits and reports division of the State Department of Health, resigned to become executive secretary of the Ohio Hospital Association, effective February 1.

\* \* \*

James H. Davis, chief of the legal division of the State Industrial Commission, has resigned to join the staff of Merriman and Sutherly, Columbus, a firm which represents employers in workmen's compensation matters.

\* \* \*

Dr. R. M. Craig, Dayton, and Dr. G. X. Schwemlein, Cincinnati, reserve officers in the U.S. Public Health Service, stationed at the Chicago Intensive Treatment Center, spoke on "The Less Common Venereal Diseases", at the Wartime Graduate Medical Meeting held at Camp Ellis, Ill., Nov. 15.

After 29 years of service at the Ohio Hospital for Epileptics, Gallipolis, Dr. John G. Schwarz, superintendent, retired Jan. 1, at his own request. His successor is Dr. George H. Roberts, an assistant physician on the staff since April, 1939.

\* \* \*

Miss Frances Atwater, formerly advertising manager of Lederle Laboratories, Inc., New York City, has joined the sales promotion staff of Wyeth, Inc., Philadelphia, as executive assistant to Stuart V. Smith, director of sales.

\* \* \*

A compulsory health insurance plan which would provide hospitalization and medical care for persons in California, financed through equal contributions of employers and employees, is being prepared for action by the California legislature.

\* \* \*

The annual meeting of the American College of Radiology, scheduled to be held in Chicago in February, has been postponed because adequate hotel accommodations could not be obtained. Instead there will be a conference of teachers of clinical radiology and a panel discussion arranged by the Commission on Hospital Standards. The board of chancellors of the college will meet Feb. 8-9.

\* \* \*

According to the *J.A.M.A.*, Dec. 16 issue, Dr. Marjorie L. Warner, a 1944 graduate of Ohio State University College of Medicine, is said to be the first woman intern at Santa Tomas Hospital, Panama City.

\* \* \*

Dr. John A. Toomey, professor of pediatrics, Western Reserve University School of Medicine, has been awarded a citation by the Cuyahoga County Chapter of the National Foundation for Infantile Paralysis, Inc., for his outstanding research on the disease.

\* \* \*

Dr. Jonathan Forman, recently appointed professor of the history of medicine, Ohio State University College of Medicine, is presenting a series of talks on early Ohio physicians at 6:30 P.M. each Thursday over the University's radio station, WOSU.

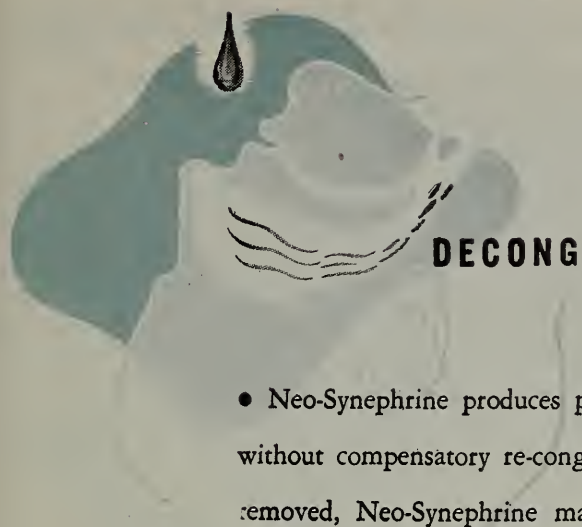
\* \* \*

Dr. A. I. Ludlow, Cleveland, was recently elected a trustee of Western Reserve University.

\* \* \*

Dr. Peter Irving, Secretary and General Manager of the Medical Society of the State of New York and Managing Editor of the *New York State Journal of Medicine* since 1937, died Dec. 28, 1944, at Roosevelt Hospital, New York City. He was 66 years old.





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- Neo-Synephrine produces prompt and enduring nasal decongestion, without compensatory re-congestion. When the cause of congestion is removed, Neo-Synephrine may be discontinued immediately without aggravation of symptoms.

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**PROMPT**, prolonged nasal decongestion through local vasoconstriction following topical application.

**EQUALLY EFFECTIVE** upon repeated use.

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**CILIARY ACTION** is not appreciably impeded.

**RELATIVE FREEDOM** from systemic effects widens the range of usefulness for Neo-Synephrine—manifestations of central nervous system stimula-

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**INDICATED** for symptomatic relief in the common cold, sinusitis, nasal manifestations of allergy, and similar conditions.

**ADMINISTRATION** may be by drop-per, spray, or tampon.

FURTHER FACTS FOR YOUR REFERENCE FILE WILL BE GLADLY SENT ON REQUEST

# Twelve Names Added to Military Roster; Total 3,106 Now In Services; Names of Those Winning Promotions

MILITARY roster of the Ohio State Medical Association stood at 3,106 as this issue of *The Journal* went to press, divided as follows: Army, 2,597; Navy, 436; other services, 73. The names added to the roster, those winning promotions, and a breakdown by counties follows:

## NAMES ADDED TO MILITARY ROSTER

| Name                       | City       | Rank                    |
|----------------------------|------------|-------------------------|
| Anderson, Hugh R.          | Cleveland  | 1st Lt., U.S.A.         |
| Bray, Maurice M.           | Cleveland  | 1st Lt., U.S.A.         |
| Clark, Charles Milton, Jr. | Cleveland  | 1st Lt., U.S.A.         |
| Conn, James J.             | Columbus   | Asst. Surg., U.S.P.H.S. |
| Crook, Charles L.          | Cincinnati | 1st Lt., U.S.A.         |
| Dowell, Charles H.         | Carrollton | Capt., U.S.A.           |
| Gallagher, Clarence M.     | Cincinnati | Capt., U.S.A.           |
| Marks, Matthew O.          | Youngstown | 1st Lt., U.S.A.         |
| Perrine, George B.         | Cincinnati | 1st Lt., U.S.A.         |
| Preuss, Siegfried S.       | Cleveland  | 1st Lt., U.S.A.         |
| Rini, Anthony C.           | Ravenna    | 1st Lt., U.S.A.         |
| Sundgren, Vincel           | Cleveland  | Lt. (j.g.) U.S.N.       |

## WIN PROMOTIONS

| Name                 | City              | Rank               |
|----------------------|-------------------|--------------------|
| Anderson, John G.    | Lynchburg         | Major, U.S.A.      |
| Barrows, Emil L.     | Cincinnati        | Capt., U.S.A.      |
| Bonnot, Bernard R.   | Canton            | Lt., U.S.N.        |
| Barth, Walter M.     | Cleveland         | Capt., U.S.A.      |
| Braden, Spencer      | Cleveland         | Lt. Col., U.S.A.   |
| Brettell, Howard W.  | Steubenville      | Major, U.S.A.      |
| Brinker, Herbert     | Cincinnati        | Major, U.S.A.      |
| Brown, Russell N.    | Centerville       | Capt., U.S.A.      |
| Chamberlain, Webb P. | Cleveland         | Major, U.S.A.      |
| Charvat, Thomas F.   | Cleveland         | Lt. Comdr., U.S.N. |
| Essig, Joel A.       | Cincinnati        | Capt., U.S.A.      |
| Falk, John H.        | Cincinnati        | Major, U.S.A.      |
| Feltes, E. J.        | Cleveland         | Capt., U.S.A.      |
| Folger, G. Keith     | Cleveland         | Lt. Col., U.S.A.   |
| Hanrahan, Frank, Jr. | Cleveland Heights | Capt., U.S.A.      |
| Hochwalt, Jerome P.  | Lebanon           | Capt., U.S.A.      |
| Krakoff, Morris A.   | Columbus          | Capt., U.S.A.      |
| Lobe, Samuel         | Cincinnati        | Major, U.S.A.      |
| Mahaffey, Howard W.  | Columbus          | Capt., U.S.A.      |
| Missal, Sylvester C. | Cleveland         | Col., U.S.A.       |
| Miessner, Alfred D.  | Port Clinton      | Major, U.S.A.      |
| Obert, Charles       | Cleveland         | Capt., U.S.A.      |
| Roettig, Louis C.    | Columbus          | Capt., U.S.A.      |
| Schaen, Irvin R.     | Middletown        | Capt., U.S.A.      |
| Shannon, Wm. G.      | Cincinnati        | Major, U.S.A.      |
| Shoupe, Thomas R.    | Findlay           | Capt., U.S.A.      |
| Skinner, Geo. Calvin | Cincinnati        | Capt., U.S.A.      |
| Spyker, Mitchell A.  | Columbus          | Capt., U.S.A.      |
| Woldman, Edward E.   | South Euclid      | Lt. Col. U.S.A.    |

## TABULATION BY COUNTIES

|                    |                     |                    |
|--------------------|---------------------|--------------------|
| Adams ..... 2      | Clark ..... 37      | Fairfield ..... 9  |
| Allen ..... 38     | Clermont ..... 9    | Fayette ..... 2    |
| Ashland ..... 12   | Clinton ..... 8     | Franklin ..... 248 |
| Ashtabula ..... 18 | Columbiana ..... 11 | Fulton ..... 6     |
| Athens ..... 10    | Coshocton ..... 4   | Gallia ..... 5     |
| Auglaize ..... 6   | Crawford ..... 9    | Geauga ..... 4     |
| Belmont ..... 14   | Cuyahoga ..... 786  | Greene ..... 7     |
| Brown ..... 4      | Darke ..... 6       | Guernsey ..... 7   |
| Butler ..... 30    | Defiance ..... 4    | Hamilton ..... 508 |
| Carroll ..... 2    | Delaware ..... 7    | Hancock ..... 12   |
| Champaign ..... 9  | Erie ..... 11       | Hardin ..... 7     |

|                    |                      |                     |
|--------------------|----------------------|---------------------|
| Harrison ..... 4   | Medina ..... 13      | Ross ..... 23       |
| Henry ..... 3      | Meigs ..... 3        | Sandusky ..... 12   |
| Highland ..... 7   | Mercer ..... 6       | Scioto ..... 20     |
| Hocking ..... 4    | Miami ..... 15       | Seneca ..... 12     |
| Holmes ..... 2     | Monroe ..... 0       | Shelby ..... 7      |
| Huron ..... 17     | Montgomery ..... 163 | Stark ..... 101     |
| Jackson ..... 1    | Morgan ..... 3       | Summit ..... 162    |
| Jefferson ..... 28 | Muskingum ..... 9    | Trumbull ..... 27   |
| Knox ..... 11      | Noble ..... 1        | Tuscarawas ..... 20 |
| Lake ..... 18      | Ottawa ..... 9       | Union ..... 2       |
| Lawrence ..... 7   | Paulding ..... 2     | Van Wert ..... 9    |
| Licking ..... 17   | Perry ..... 4        | Vinton ..... 2      |
| Logan ..... 8      | Pickaway ..... 5     | Warren ..... 4      |
| Lorain ..... 40    | Pike ..... 2         | Washington ..... 8  |
| Lucas ..... 182    | Portage ..... 3      | Wayne ..... 14      |
| Madison ..... 6    | Preble ..... 7       | Williams ..... 8    |
| Mahoning ..... 141 | Putnam ..... 6       | Wood ..... 19       |
| Marion ..... 16    | Richland ..... 38    | Wyandot ..... 3     |
| Total              |                      | 3106                |

## Navy Issues Urgent Appeal for More Medical Officers

"The war is a long ways from being over", says a statement issued by the Office of Naval Officer Procurement, Detroit, Michigan.

The enlistment of many more doctors rates a triple-A priority by the U.S. Navy today, the Detroit office emphasizes. Their skills and talents are required on ships, at advanced bases and continental shore stations in ever-increasing numbers.

In seeking the enlistment of hundreds of doctors, the Navy is inviting the applications of physicians in a very wide range of practices and ages.

When accepted the doctor's rank as a naval officer will be determined by age, education and background. Women also are being accepted.

Complete information regarding medical officers' commissions in the Navy may be obtained at the Office of Naval Officer Procurement, Book Bldg., 1249 Washington Blvd., Detroit, Mich.

## New Hospital Ships

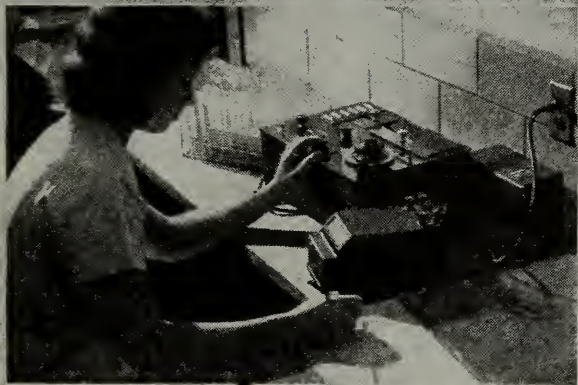
Five more troop ships are going to be converted into hospital ships to speed the return of sick and wounded soldiers from overseas, the War Department announced recently.

The new ships which will have a capacity of 5,355 patients, will boost the fleet of ambulance vessels to 29 with a total capacity of more than 18,000. They will be ready for service by June or July.

The surgeon general's office recently reported that sick and wounded are being returned to this country at a rate of 200,000 monthly.

Included among the five troop ships is the *Saturnia*, a 19-knot former Italian luxury liner. Other vessels are the former French liners *Colombie* and *Athos II* and the former United States liners *Republic* and *President Tyler*.





DILUTION TEST—Turbidimetric method to determine Penicillin unit value of preparation. As a double check on potency, Wyeth also employs the cylinder plate method.

## PENICILLIN CONTROL

The precision that goes into the manufacture of all Wyeth products necessarily played an important part in the development of Penicillin. In the early days, when little was known of the quantitative behavior or potency of Penicillin, Wyeth biochemists worked constantly to develop procedures and methods of standardization that would give the entire world a uniform product as well as uniform potency of the dosage unit of Penicillin. When its chemical nature became more

clearly understood, Penicillin, as developed by Wyeth, had to meet newer and even more exacting tests—tests employing instruments of precision and requiring analytical, chemical and bacteriological skill. Through the system of control thus developed, Wyeth Penicillin meets the most exacting requirements, including those of government agencies and clinical investigators.

WYETH INCORPORATED • PHILADELPHIA



MOISTURE TEST—Wyeth Penicillin shows a moisture content of less than 1%.

STERILITY TEST—Proves freedom from occurrence of growing micro-organisms.

PYROGEN TEST—Correctly shows absence of fever-producing substances.

The PRESTIGE in the name WYETH\* has been gained by generations of faithful service to the medical profession through the retail drug industry:

Since 1860 WYETH has consistently provided medicinals of first quality and dependability. Today a complete line of pharmaceutical, nutritional and biological products bear the name WYETH—your assurance of the finest in laboratory preparations.

A strictly ethical advertising program keeps the name WYETH before the profession; such as the reproduced Penicillin advertisement currently appearing in medical journals.

\*REG. U. S. PAT. OFF.



# WAR NOTES

An appreciative note from Lt. Col. Edward E. Woldman, Cleveland, chief of the Medical Service in a station hospital in England, apparently had a rough time en route. The partially-burned and charred envelope had a sticker from the Post Office Department attached, reading as follows: "This letter was recovered from a mail-carrying airplane that was in an accident".

\* \* \*

Capt. Robert J. Sating, Cleveland, recipient of the Silver Star for distinguished gallantry in action in the Mediterranean Theater, last year, is reported to have been wounded in action while serving with a medical unit in Germany, Dec. 11.

\* \* \*

Col. Anthony J. Lanza, Director of the Occupational Health Division, Preventive Medical Service, Office of the Surgeon General, has retired from active duty to resume his work as assistant medical director of the Metropolitan Life Insurance Company.

\* \* \*

Maj. Carl W. Kumpe, Hillsboro, home on leave recently, told the local Rotarians of some of his experiences in France and England, including a first-hand account of robot bombing.

\* \* \*

Lieut. Robert Mauck, A.A.F., son of Stanley R. Mauck, executive secretary of the Columbus Academy of Medicine, played an important role in the historic relief of Bastogne. He was the navigator of the first glider-towing plane to reach the besieged city, and appropriately enough, the passengers were medical officers and enlisted men, and medical supplies. With the Ninth Troop Carrier Command, Bob was in on the invasion of Normandy, the invasion of Southern France and many other tough missions.

\* \* \*

Medic, read the following editorial from the Jan. 5 issue of *The New York Times* and take a bow:

"The 'medic' is a must in any fighting force. He is likely to combine the functions of Kipling's Gunga Din, Florence Nightingale, the Good Samaritan and the most skillful surgeon science has produced. He frequently does so at the cost of his own life. Unarmed stretcher-bearers seek out the wounded where the shells are still striking. Because they know that time is of the essence, they are always in a hurry. Sometimes a complicated operation has to be performed in a foxhole. During the Metz offensive a 19-year-old

medical aide saved a doughboy's life by cutting a fountain-pen tube into his throat with a pocket knife. But they try hard to get the victim to the nearest hospital. Maybe it is a blasted barn or an open cellar. It may be a tent over the brow of the next hill, with the surgeons operating under enemy fire. At Bastogne two or three surgeons had to handle 800 patients with nothing to dull their pain but cognac. Everybody cheered when five more surgeons got through by plane and glider. (Note: This plane was navigated by an Ohioan. See above.)

"There is little glory in the Medical Corps. It is just hard, dirty work and mighty dangerous. The Red Cross seems to mean little to the enemy. He has bombed hospital tents from Anzio to Aachen. These medics are tough, but among the torn and dying men learn to be tender, too. They shun glory, but they have their pride. They are proud to have saved 97 out of every hundred wounded. They are proud that their miracle drugs and blood banks send from 50 to 80 back to fight again. They are proud because nobody in our whole vast Army, not even the foremost combat crew or the deadliest flying wing, has done a finer job than the Medical Corps."

\* \* \*

When General Douglas MacArthur landed on Luzon, Jan. 10, he was accompanied by Lt. Col. Roger O. Egeberg, Cleveland, his personal aide and physician, according to news dispatches.

\* \* \*

After 29 months in the Southwest Pacific Theater of Operations, Maj. Louis Adelman, Columbus, has returned to the United States and is now being processed through the Army Ground and Service Forces Redistribution Station at Miami Beach, Fla.

\* \* \*

Capt. Louis H. Roddis (MC), U.S.N., twice editor of the *Naval Medical Bulletin*, reported for duty at the Bureau of Medicine and Surgery October 30 and has been made responsible for the preparation of the official naval medical history of the war. He recently completed thirty-one years of naval service.

\* \* \*

From "Somewhere in the Philippines", Major J. G. Anderson, Lynchburg, V-mails as follows:

"First of all I want to express my appreciation for the card maintaining my full membership to the Association. It makes you feel that the Association is trying to maintain their standards so that we may return and take up where we left off. I regret that I have not written sooner and informed you of my whereabouts. I just received the September issue of *The Journal* and I know how much I enjoyed reading the news.





Original illustration  
from Principles and  
Practice of Obstetric  
Medicine, by D. D. Davis,  
M.D., London, 1836.

## TO EASE THE BURDEN

It is the province of the physician to assist the patient through difficult periods of life, whether they be the result of structural or functional defects, and to contend with those conditions which oppose natural, healthy functioning of the human body. Schering is privileged to share this province by developing and providing new and rational therapeutic agents for the physician which enable him effectively to combat many of the problems of adolescence, pregnancy, and the menopause.

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SCHERING CORPORATION, BLOOMFIELD, N. J.



I especially enjoyed reading about other Ohio physicians in the armed service and I suddenly realized I had not sent in any news since I entered the service in 1942.

"Your records show that I was in practice in Lynchburg before I entered the service. After completing a tour of the States with the medical department from battalion surgeon on up, I finally landed in the Corps Surgeon's Office as assistant Corps Surgeon. Left the States some time ago (security regulations prevent stating the exact time) for the Pacific Theater. We operated in New Guinea for a while and I am happy to say that I was among the many Ohio physicians in making the first landing on the Philippines. My close association with the medical service has been very interesting and the work performed by the medical officers has been a record of which the medical profession should be proud. It is gratifying to learn through *The Journal*, the stand the Association is taking on socialized medicine. At least it gives us hope that we will be able to return and enjoy private practice without outside interference. Again I want to thank the Association for *The Journal* and hope our mail situation improves so I may receive it more regularly."

\* \* \*

Back from overseas, Comdr. John B. Anderson, Cleveland, is now on duty at the Naval Air Station, Deland, Fla.

\* \* \*

Reporting a change of address, Capt. Homer J. Davis, Cleveland, battalion surgeon with an AAA outfit, wishes there was a little more sun in "sunny" Italy. He says there is plenty of rain and mud all over.

\* \* \*

According to press dispatches, Capt. Joseph H. Shepherd, Columbus, with a medical detachment of the 35th Division in France, has been wounded twice, wears the Purple Heart with one cluster, and has received the Bronze Star Medal. Although wounded, Capt. Shepherd has never left his unit.

\* \* \*

Major Matthew Ginsburg, Toledo, has this to report from "Somewhere in Italy", dated Nov. 28:

"The August, 1944, issue of *The Journal* arrived today and in response to your 'It's a serious situation, sir', plea, I offer the following information concerning myself. My assignment is on the U.S. Army Hospital Ship Ernest Minds, where I am Chief of Medical Service. Our locale of operation is in the Mediterranean area at such ports as Naples, Leghorn, Marseille, Oran and Corsica. Transportation of battle casualties is obviously our job; it is both interesting and educational. One has an opportunity to see much of the world during such a tour of duty. Needless to say, I have come across some of my Toledo friends in North Africa and Italy and the experience is a most happy one. Our hospital ships are completely equipped floating hospitals; the facilities are elaborate and modern. The Red Cross, Special Service and the Chaplain Corps do yeoman work and are excellent morale factors. Nothing has been spared to see that our men get the best available service. It is an honor and privilege to be able to serve in this worthy cause."

Lieut. Comdr. J. D. Hayden, Akron, previously medical officer for the V-12 unit at Oberlin College, Oberlin, was recently transferred to sea duty.

\* \* \*

Lieut. Robert F. Paryzek, A.A.F., son of Dr. and Mrs. Harry V. Paryzek, Cleveland, was killed in a plane accident near Ontario, Calif., Dec. 29. He was piloting a twin-engined fighter plane which went into a spin and crashed. In the Air Force since Feb. 22, 1943, Lieut. Paryzek, 21, won his wings at Williams Field, Ariz., last May. He had been home on his last leave in November, and was on a routine combat training flight preparatory to going overseas when the fatal accident occurred. Lieut. Paryzek was a graduate of Shaker Heights High School and of the Valley Forge Military Academy. He is also survived by two younger sisters.

\* \* \*

A total of 183 physicians died in military service in 1944. *The Journal of the American Medical Association* reported recently. Seventy were killed in action, and 113 others died from natural causes. Since the outbreak of the war, *The Journal* has recorded the deaths of 326 physicians who died while serving with the armed forces.

\* \* \*

Capt. Fred B. Hapke, Troy, is somewhere along the Ledo Road in India, with a field hospital unit.

\* \* \*

Thanks to the Staff Bulletin of Good Samaritan Hospital, here are some bits of interesting news about Cincinnatians serving Uncle Sam around the world: Lieut. Comdr. J. C. Danahy, detached from a mobile hospital unit in New Caledonia, flown to Hawaii, assigned to sea duty as senior medical officer on a ship "headed for big events". . . . Lieut. Comdr. Carroll J. Fair, chief medical officer at the Spar Training Station, Palm Beach, Fla. . . . Lt. Richard D. Bryant, on a new tanker, presumably on the Pacific. . . . Maj. N. J. Gianestras, chief of orthopedics, at Regional State Hospital No. 1, formerly the Miami-Biltmore Hotel, Miami, Fla. . . . Capt. Wm. Foley, in Burma for 14 months. . . . Lt. Melvin J. Weber, out in the Pacific as a flight surgeon in the Navy Air Corps. . . . Capt. J. Gordon Dixon, in New Guinea, one of the wettest spots he has ever seen. . . . Lt. Joseph Wright, after seeing some of the wounded being brought into a hospital in England fresh from the front, comments: "What a sight—you know you're really in a war—but all of them were smiling and in top spirits". . . . Major Thomas A. Weaver, Jr., in Italy, doing plenty of neurosurgery. . . . Capt. Foster M. Williams, in England, on same staff as Capt. John Hauser, who was recently returned to the States to recuperate from injuries received in an automobile accident. . . . Capt. R. S. Piper, either in England or France. . . . Capt. James A. Schaal, in charge of Officers' Wards at the hospital, Keesler Field, Biloxi, Miss. . . . Lt. J. MacDonald, of the Good Samaritan Laboratory staff,





## *The Latest Spirochaeticide*

acceptable to the United States Public Health Service  
for the new rapid treatment of syphilis (August 31, 1944)  
is Dichlorophenarsine Hydrochloride, U. S. P. This new-  
est anti-luetic is made available by E. R. Squibb & Sons as

*Clorarsen*  
TRADEMARK

For detailed information, please address Professional Service  
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**SQUIBB**

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

went through France with an anti-tank battalion, in the thick of the fighting. . . . Lt. Charles Pfahler, after examining inductees at Houston, Texas, now has a New York address. . . . Capt. William R. Tepe, in a station hospital at Saipan, where the going was plenty tough. . . . Capt. R. J. Anzinger, in an early Summer trip to Nazareth, visited Jacob's Well and Mary's Well. . . . Capt. Dan Rivers now stationed at Spokane, Wash., where they are getting their share of casualties including tropical diseases. . . . Major Herb. Brinker, now in Southern France, visited the Holy Father while in Italy. . . . Capt. Richard Schroder, with front line troops, in the thick of it in France. . . . Capt. Tom Radley, promoted recently, at Port DuPont, Del.

\* \* \*

With the AAF in China, Capt. N. G. Amato, Cincinnati, sent holiday greetings to *The Journal*, inscribed on a Five Dollar China banknote.

\* \* \*

Lt. Bernard R. Bonnot, Canton, recently assigned to the U. S. Naval Hospital, Norman, Okla., has been around a good bit since joining the Navy in Oct., 1942. He has been at N.T.S., Great Lakes, Ill.; N.A.C.S.B., Chicago, Ill.; U. S. Naval Hospital, San Diego, Calif.; and in the Chartered Transport Pool (Pacific). He made three trips into the Pacific. One ship went aground at Ewiwetok and had to be towed back to the States. Dr. Bonnot observes that he "traveled in dangerous waters but never saw a Jap".

\* \* \*

On his second tour of sea duty, Comdr. William J. Sheehan, Cleveland, is chief of surgery on the U.S.S. Relief AH-1.

\* \* \*

Major William L. Faul, Georgetown, back in the states after a year in the South Pacific, is depot surgeon for the A.S.F. Depot at Columbus.

\* \* \*

Infirmiry surgeon at a supply depot in India, Capt. Ben Widzer, Cleveland, says he "is caring for the various routine and tropical conditions that occur in this Land of Mystery and Romance, where jackals howl all night and the killing of a cobra is not an unusual occurrence". Capt. Emery Braum, Akron, also is stationed there, and Capt. Emil L. Barrows, Cincinnati, was on duty there until recently.

\* \* \*

Capt. J. I. Goodman, Cleveland, is chief of the gastro-intestinal section of a general hospital in England.

\* \* \*

Sending a new APO from England, Capt. P. E. Reading, Painesville, says that the last *Journal* he had was the October issue, received at Camp Pickett, Va., and he doesn't want to miss any issues, because he "is happier to have that arrive than any other papers".

Major Harold J. Gordon, Columbus, chief of the Bureau of Venereal Disease of the State Department of Health, before he went into the service about two years ago, is in France, at the Office of the Chief Surgeon, ETOUSA, Evacuation Section.

\* \* \*

Lieut. Col. Anthony Ruppertsberg, Jr., Columbus, rated the top Christmas gift for service men—a reunion with his family, after two and a half years in the South Pacific. He had spent Christmas of 1942 and 1943 in the Fiji Islands, where early in 1943 he was detached from the 37th Division and placed in command of an Army hospital. Shortly before leaving for home he was named base surgeon on the Fijis. Col. Ruppertsberg reported at Miami, Fla., Dec. 30 for reassignment.

\* \* \*

Add to the Ohio Colony in the Phillipines these two Miami countians: Capt. Paul E. Foy, Troy, who went in on that landing at Leyte with an amphibious tank battalian, and Lt. J. F. Beachler, Jr., Piqua, with a convalescent hospital group.

\* \* \*

Overseas since last October, Maj. G. D. Fridline, Ashland, has been reported missing in action in Germany since Dec. 21. He was called to active duty in Oct., 1940, as commanding officer of Co. H, 112th Med. Reg., Ohio National Guard, and was stationed at Camp Shelby for some time with the 37th Division. Later Maj. Fridline was assigned to the Medical Detachment of the 166th Infantry.

\* \* \*

Maj. Adelbert John Godfrey Kuehn, Toledo, better known to his medical colleagues as "Cy", now with a general hospital unit in France, has the following to report, via a letter to the Toledo Kiwanis Club, published in *The Bulletin of the Toledo Academy of Medicine*:

"If I would try to bring you up to date on my own wanderings both in the land of the bob (shilling) and quid (British army term for pound—I learned when I served with the British 107th General at Oxford last January) and now in France from my first humble cow pasture home—sleeping on the ground—eating K-rations and using a helmet for everything from protection—to washing my clothes—I would have to write a young book. But here are a few high lights. D-Day found me heading up two specialist teams—a neuro surgical and a chest team with the 305th Station Hospital on the far shore. We got many of the early casualties and often worked around the clock. From there, our group shifted to the 67th General Hospital—the excellent Maine Unit (I'm sure the big boys didn't know they had a fine mess and Club—these chaps from Maine). Next with that uncertain certainty so well known in the Army I found myself on the receiving end of a V. O. C. G. (Verbal order I. General) to report at once to the 40th General Hospital. So I



# RALES by RADIO



*"Your man has an asthmatic attack . . . wrap him in blankets with hot water bottles and give him an injection of Adrenalin Chloride"*

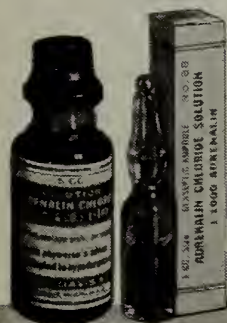
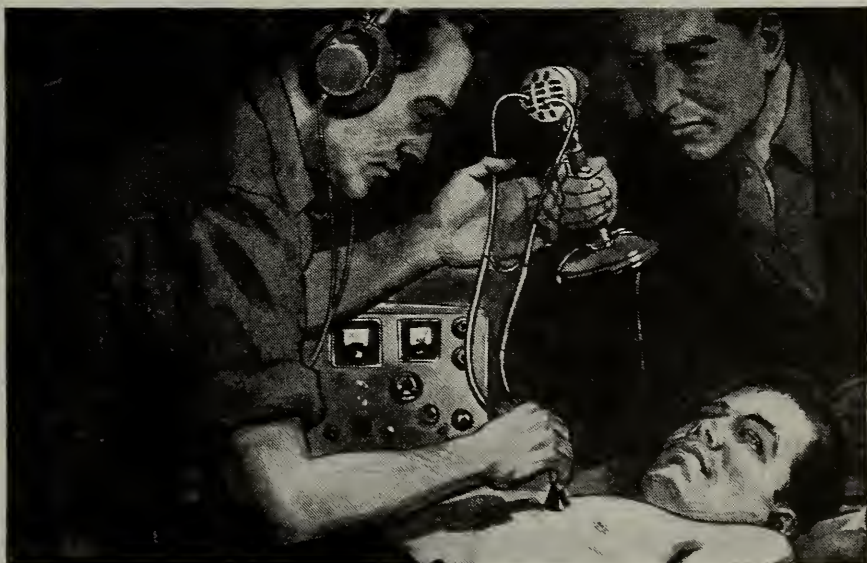
Spanning hundreds of miles of ocean, these life-saving directions of a Navy doctor in Hawaii were carried by radio to a small vessel "somewhere in the Pacific" on which a seaman lay unconscious. A stethoscope over the patient's chest with ear pieces pressed close to the microphone had made it possible for the physician to hear the breath sounds and heart-beat in Honolulu.

Thus in war, as in peace, Adrenalin Chloride is the first thought of the physician for the prompt relief of asthmatic paroxysms.

Its ability to relax spasms of bronchial musculature, to stimulate the heart with increase in cardiac output, to raise systolic arterial pressure and widen pulse pressure, and to constrict blood vessels of the skin gives Adrenalin a dynamic and diversified therapeutic action.

In addition to its use in bronchial asthma, Adrenalin (epinephrine) is widely employed as a hemostatic, as a vasoconstrictor in vascular engorgement of the nasal passages, to prolong the effect of local anesthetics, and as an aid to resuscitation in shock and anesthesia accidents.

The details of this dramatic story were reported in daily newspapers on December 6, 1944—a tribute to the skill and ingenuity of the physicians in our Armed Forces.



# Adrenalin

1:100 Solution  
1:1000 Solution

**Parke, Davis & Company**  
DETROIT 32 • MICHIGAN



did—finding myself assigned to this regular Army General Hospital as Chief of Anaesthesia and Operating Room Section. They were staging, and so with one foot on the gang plank, a bloke has no chance to get gang plankitis, does he? It took only one week to find myself marching up a road in France with a full pack on my nearly 45-year-old shoulders—to the cow pasture I spoke of earlier in this letter. Again things happened suddenly and we found ourselves going forward surrounded with no real information but as many rumors as a bullish market. In our wildest dreams we never expected to move into a French Hospital that the Jerries left just one week before we took over. But that is where we found ourselves only a little over a fortnight ago. There was still a bit of mopping up going on when we came in—and how we came in. Some day I'll tell you about our ride. For example—one night we rode all night to find out the next a. m. we had just covered about 15 miles as the crow would fly. We came in to find no A. P. O. established and only K-rations but the Jerries did leave a potato, beet and cabbage patch we put to good use. Rommel had been a patient in this hospital—in fact I use his kitchen as my bath room at this very moment. Jerry did a good job stripping this place—left nothing but empty wine and cognac bottles and seven X patients the French planted for us—even threw away all the keys. But there was work to be done—so box after box of supplies from the Toledo Medical Depot started to roll in after we looked all over France for them.

"It might be of interest to know we had 5200 boxes—or something like that—72 goods wagons besides our own wagon train. Yesterday we really showed our efforts were not wasted when we had a total of 46 operations. That's no lazy day's work in any league.

"By the way, Fred Astaire visited our hospital day before yesterday—shy, bashful Fred Astaire danced his best for his G. I. audience—danced in his G. I. U. S. O. uniform—his dances from Top Hat. I wonder what he must have thought having a stage built in front of an old Chapel—with the windows all shattered and using a G. I. blanket as his drop curtain? Then his sincere and humble thank you for the privilege of dancing for those chaps who have just come back from a real show was something. So this letter was the result of a night off (my first) and the fact we're restricted to the post (all key men).

"But I warn you—one and all—it's going to be hard keeping me down on the farm after I've seen Paree."

\* \* \*

News about Akron medical officers picked up from the Service News Letter of the Summit County Medical Society: Capt. J. G. Repasky, on detached service as port surgeon, somewhere in the British Isles. . . . Maj. S. H. Eisenberg, in France with the Troop Carrier Command of the Airborne Army. . . . Capt. Harry G. Lieberman, a year ago in the Italian mountains, now in the French Vosges hills with an infantry outfit. . . . Lieut. Comdr. J. D. Hayden, reported recently on the West Coast as senior medical officer aboard an attack transport. . . . Lieut. Comdr. A. E. Davis, on the U.S.S. Relief, a hospital ship, now in port on the West Coast for an overhaul. . . . Maj. W. H. Falor, team chief of a general sur-

gery team, on detached service since his arrival with a Field hospital in Normandy, has followed the fighting through the Brest-Crozon campaign, across France, up into Belgium, Luxembourg and now Holland.

\* \* \*

After about two years at the Marine Air Base, Cherry Point, N.C., Lieut. Comdr. Harve M. Clodfelter, Columbus, is now on sea duty, aboard a ship in the Pacific.

\* \* \*

Lieut. Col. Claude S. Perry, Columbus, has "returned to duty" after having previously been reported "slightly wounded" on Dec. 17. Col. Perry is with a general hospital unit in Belgium. He sent Christmas greetings to the State Headquarters Office staff from Aachen.

\* \* \*

Recent changes of address within the United States: Capt. J. Wertheimer, Painesville, Sta. Hosp., Erie Proving Ground, LaCarne; Capt. Alex. S. Fisher, East Liverpool, 41st Photo. Ren. Sq., AAB, Muskogee, Okla.; Lt. Col. F. M. Wadsworth, Mansfield, Fletcher Gen. Hosp., Cambridge; Capt. Irvin R. Schaen, Middletown, Darnall Gen. Hosp., Danville, Ky.; Lt. R. N. Paul, Dayton, Sta. Hosp., Randolph Field, Texas; Capt. George M. Emery, Ashland, Sta. Hosp., Camp Wolters, Texas; Lt. Comdr. M. M. Riddell, Fremont, Goat Island, San Francisco, Calif.; Capt. Irwin H. Stolar, Cleveland, 1550 S.U., Reg. Hosp., Fort Knox, Ky.; Capt. G. E. Garvin, Blanchester, 4032nd B.U., A.T.S.C., Central Section, Detroit, Mich.; Maj. Paul McConnell, Youngstown, 86th Evac. Hosp., Camp Bowie, Tex.; Lt. Col. J. H. Marshall, Findlay, executive officer, Crile Gen. Hosp., Cleveland; Capt. John M. Karch, Cincinnati, AAB, Pyote, Texas; Maj. James E. Harsha, Washington C. H., Commanding Officer, 378th Sta. Hosp., Camp Berkeley, Tex.; Lt. Col. Clarence W. Hullinger, Springfield, Prisoner of War Gen. Hosp. No. 2, Camp Forrest, Tenn.; Capt. Harold F. Burkons, Shaker Heights, AAF Convalescent Hosp., Bowman Field, Louisville, Ky.; Lt. Col. States D. McCoy, Columbus, Hq., 51st Med. Tng. Bn., Camp Berkeley, Tex.; Lt. Comdr. J. C. E. LaVallee, Cincinnati, Armed Forces Induction Station, Fort McClellan, Ala.; Capt. Jerome P. Hochwalt, Lebanon Sta. Hosp., Camp Shanks, N. Y.; Capt. Morris Hyman, Cincinnati, Det. Pts., Mayo Gen. Hosp., Galesburg, Ill.; Capt. W. J. Brown, Conneaut, Personnel Center, SCU 4494, Ft. McPherson, Atlanta, Ga.; Maj. Boni E. Petcoff, Toledo, Hq. and Hq. Sec., 1560 S.U., Camp Atterbury, Ind.; Lt. Comdr. B. S. Park, Painesville, c/o Commdt., 1st Nav. Dist., Boston, Mass.; Lt. Edwin E. Domall, Toledo, N.T.C., Great Lakes, Ill.; Lt. Charles Froug, Dayton, 112th Evac. Hosp., Camp Berkeley, Tex.; Capt. Francis X. L. Baurichter, Cincinnati, P.O.W.C., Huntsville, Tex.; Lt. (j.g.) J. L. Bilton, Cleveland, c/o Comd. Gen., Camp Lejeune, N.C.; Capt. Thos. R. Shoupe, Findlay, 552 M.H.S.P., Dispensary, Staten Island, N.Y.; Capt. Karl Ritter, Lima, 247th AFB, AAF, Salina, Kans.; Lt. Thos. S. Gerspacher, Euclid, USCG, Westhampton Infirmary, Westhampton, N.Y.; Lt. Col. A. A. Hall, Columbus, Commanding Officer, Sta. Hosp., Erie Proving Ground, LaCarne.





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\*Reiter, P. J., Experience with Benzedrine, Ugeskr. f. laeger, 99:459-460, 1937.



## **BENZEDRINE SULFATE TABLETS**

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### "HE WAS A CITIZEN OF RARE ATTAINMENTS"

Few physicians have played such an influential role in the activities of the medical profession as the late Dr. Geo. Edw. Follansbee, whose death occurred on New Year's Day at his home in Newburg, near Cleveland.

The fact that the name "Geo. Edw. Follansbee" has appeared in the columns of *The Ohio State Medical Journal* so many times is mute evidence of his great interest in the advancement of the science and art of medicine and of his many outstanding contributions to programs which have been of value to his profession and the public.

Dr. Follansbee was the recipient of every honor which his local and state medical societies had to confer. As a medical leader in Cleveland, he took a prominent part in making the Cleveland Academy of Medicine one of the country's outstanding medical societies. As an active official of the Ohio State Medical Association—as Councilor, President, and for many years chairman of the Committee on Medical Economics—he initiated many activities which have made that organization an efficient medical organization.

As a member, for many years chairman, of the Judicial Council of the American Medical Association, Dr. Follansbee was a power in medical organization on a national scale. He was recognized as the best informed authority in the country on medical ethics and judicial matters arising in medical organization. Moreover, he was regarded as an unusually keen analyst of economic and social factors affecting the practice of medicine, having served on the Committee on the Costs of Medical Care and on many other study groups in this field. Because of his rare ability and judgment, his counsel was continuously being solicited by professional and non-professional organizations, as well as by scores of individual physicians. Many physicians will never forget the sound advice which he gave them when they sought his guidance on their personal and professional problems.

But, in addition to being a leader in medical organization and an authority on administrative, ethical and judicial questions, Dr. Follansbee was an outstanding surgeon and a gentleman with scholarly tastes, possessing charm and graciousness which won for him a host of friends and acquaintances who loved and admired him. As one commentator has said: "He was a citizen of rare attainments". And to quote another: "A

test of the days to come will be their ability to produce men of the stature of Dr. Geo. Edw. Follansbee".

The death of Dr. Follansbee is a distinct loss to the entire medical profession and to the nation. Both have benefited tremendously from his distinguished services.

---

### DO YOU NEED YOUR NURSE WORSE THAN THE ARMY NEEDS HER?

We can't get steamed up about the threat of the Federal Government to draft nurses for the simple reason that we feel the nursing profession will meet the demands of the services for additional nurses on a voluntary basis.

That there is a shortage of nurses in the services is apparent. That the need will be met without a draft is a safe bet. A little readjustment from within the nursing profession will do the job.

Hospital administrators and physicians can help a lot by releasing nurses for military duty if at all possible. It won't be easy for a hospital or the doctor to take as a substitute, a nurse's aide or some similar temporary assistant but it will have to be done. Sending army hospital units overseas without any nurses can't be tolerated. Those who insist on keeping nurses at home under such circumstances, will be indirectly responsible for inadequacies of care available to wounded boys on the firing lines.

---

### DOCTORS CAN HELP IN ATTACK ON ABSENTEEISM PROBLEM

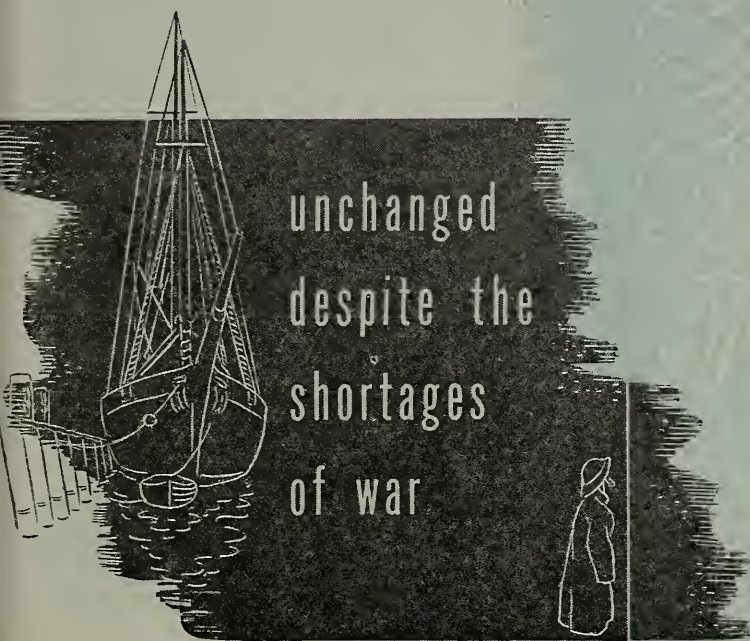
Vigorous efforts have been initiated in Ohio by the War Manpower Commission to keep workers, especially those in critical war industries, on the job so production can be increased and larger quantities made available for the armed forces.

Absenteeism constitutes a serious problem in some areas of the state. The reasons given by some workers for being off the job are sound and reasonable. This is not true in other cases. It is a known fact that some workers stay off the job when only slightly indisposed; others on the pretense of being ill.

Physicians can help a lot in keeping absenteeism at a minimum by encouraging patients with only trivial ailments to stay on the job. Obviously, sound medical judgment must be exercised and those whose condition would be aggravated by working should be told to stay at home.

Also, physicians should refuse to sign sickness





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blanks in those cases where the worker is merely using "sickness" as an excuse to stay off the job. Naturally, such cases present a real problem for the physician. Nevertheless, increased production is essential for early termination of the war, so the physician will have to be absolutely honest with himself, his patients and the entire war effort. Matters of convenience can not be tolerated under present conditions. The physician owes it to himself, the entire profession and the public to be fearless even in the face of criticism by some of his patients.

## PLENTY OF FIREWORKS ANTICIPATED ON THE POTOMAC

Straws in the wind:

Senator Pepper's Sub-Committee on Wartime Health and Education of the U.S. Senate Committee on Education and Labor has filed an interim report, after six months of hearings. (Write your Congressman for a copy or review this report, published in full in the January 6, 1945, issue of *The Journal of the A.M.A.*)

A bill to provide \$110,000,000 in Federal funds for the construction and improvement of hospitals throughout the country has been introduced in the U.S. Senate by Senators Burton, Ohio, and Hill, Alabama, according to a special bulletin published by the *Columbus Dispatch*.

Efforts are under way in Michigan to have a proposed amendment to the Michigan Constitution voted on in April which amendment would establish an all-inclusive Social Security Department in that state, including provisions for compulsory sickness and hospital insurance.

It has been reported that the California State Legislature will be asked to vote on a bill to provide compulsory health insurance for all residents of the state earning less than \$3,000 annually.

A new bill (H.R. 395) has been introduced by Congressman Dingell, Michigan, identical with the Wagner-Murray-Dingell Bill, which expired with the last Congress.

\* \* \*

Recommendations of the Pepper committee, referred to above, include the following:

That Federal grants-in-aid to states be authorized now to assist in postwar construction of hospitals, medical centers and health centers, in accordance with integrated state plans approved by the U.S. Public Health Service;

That Federal loans and grants be made available to assist in postwar urban sewerage and water facilities, rural sanitation and water facilities, and milk pasteurization plants in communities needing such facilities;

That U.S. grants be increased to encourage the creation of full-time local public health departments in all communities;

That the Army consider the feasibility and

advisability of expanding its program for induction and rehabilitation of men rejected because of physical and mental defects;

That steps be taken to increase the output of personnel with training in psychology and psychiatry to encourage the establishment of child-guidance and mental hygiene clinics;

That Federal scholarships and loans be made available to assist qualified students desiring medical and dental education;

That more Federal funds be made available to states for medical care of all recipients of public assistance.

\* \* \*

According to the *Columbus Dispatch*, the funds to be made available under the Burton-Hill bill would be available after the war for public and non-profit hospitals and allocations to states would be on the basis of population, financial need and the need for hospitals. Plans must originate within the state. No Federally suggested plans would be carried out unless approved by the states. There must be a single state agency to administer the funds. A state plan must be approved by the Surgeon General, U.S. Public Health Service, assisted by an advisory commission of eight.

\* \* \*

Yes, doctor, after doing a little addition, it is our opinion that the ensuing months promise to produce a lot of fireworks.

If you don't know your Congressman, you'd better get acquainted in a hurry.

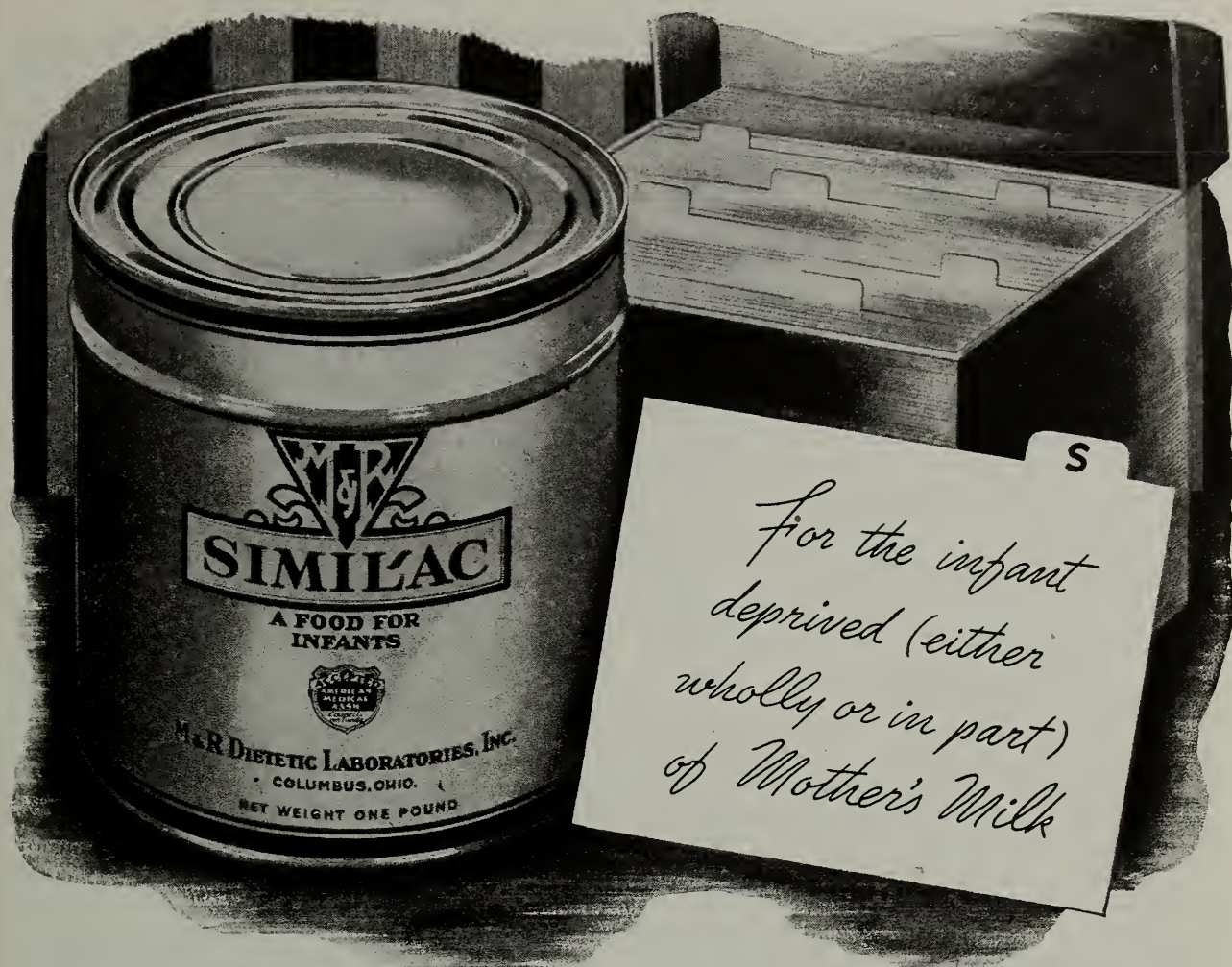
## THE JOB AHEAD IN THE WAR ON V. D.

Social Hygiene Day will be observed throughout the nation on February 7. This annual event, sponsored by the American Social Hygiene Association, deserves the wholehearted support of all physicians, as physicians have a special responsibility for the protection of health and the prevention of diseases—venereal diseases.

Although the immediate appeal is for the medical profession to assist in making the 1945 Social Hygiene Day an outstanding occasion, after all, we must regard it as only a fleeting event in the 365 days' campaign which must be waged this year against syphilis and gonorrhea, against prostitution and promiscuity and against conditions which allow these evils to flourish. In other words it is only a part of a steady campaign which must be carried on vigorously by professional and lay groups.

Gains have been made in the attack against venereal diseases but they still remain a leading menace to public health. The last compilation of national statistics shows that in 1943 a total of 861,000 cases of syphilis and gonorrhea were reported to official health agencies. This is 70 per cent more than the combined total of reported cases of diphtheria, malaria, meningitis, pneu-





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monia, poliomyelitis, scarlet fever, smallpox, tuberculosis, typhoid, paratyphoid and typhus.

Medical science has produced and perfected new methods to combat these diseases. Treatment facilities have been expanded. Physicians are better prepared now than ever before to diagnose and treat syphilis and gonorrhea. Law enforcement agencies are cracking down on organized prostitution. But, for total conquest there must be something more than finding and treating infected persons and repressing prostitution.

Additional vigorous efforts must be put forth to tell the public more and more about the dangers of sexual promiscuity which stems from individual and public casualness towards moral values, and to a great extent involving persons too immature to recognize the danger or to realize the consequences. Instruction and guidance to improve home and community conditions are needed as poor environment breeds sex delinquency. Wholesome recreation facilities should be supplied as outlets for young energies.

Physicians as individuals and as groups can, and should, take a leading role in this continuing program by:

Accepting invitations to address lay audiences or by giving radio talks on syphilis and gonorrhea;

Counseling with leaders of lay organizations who may seek their advice and aid;

Joining in the sponsorship of educational programs on these subjects;

Supporting programs to provide good recreational facilities for the youth and to eliminate social and economic conditions which are the cause of much sex delinquency;

Assist in building sound public support for law enforcement;

Cooperate with official health agencies in their venereal disease activities;

Keep themselves well informed on new methods of diagnosis and treatment, so they will be well prepared to render adequate services to infected persons.

Additional program against V.D. can be recorded in 1945 by combining a more vigorous prosecution of medical and public health procedures and the expansion of programs on the moral, social and educational sectors. There is need for the services and support of every physician in such a united attack.

#### DISPOSING OF THE RECORDS OF DECEASED PHYSICIAN

Not infrequently the heirs or executor of the estate of a deceased physician, in dealing with the question of the disposal of the records of the physician, are bothered about the legal and professional factors involved.

Based on advice from Mr. J. W. Holloway,

director of the Bureau of Legal Medicine of the American Medical Association, the following comment on this question is offered.

There are three ways in which a physician's medical records may be disposed of after his death. They may be destroyed. They may be transferred to another physician. They may be given to former patients.

In the absence of specific law requiring that records be kept for a definite time, there is no legal reason against the destruction of records by the physician's estate. However, such destruction might work to the detriment of some patients whose records would conceivably be of value if placed into the hands of a succeeding attending physician.

Also, such action might destroy records which would be necessary to rebut claims based on alleged malpractice, filed within the statutory period. How long records should be kept for this reason is a question which the legal advisors of the estate must decide. Obviously, records that may be of value in the collection of unpaid accounts should be kept until such bills are paid or otherwise disposed of.

An estate may transfer medical records to another physician. If this is done without the consent of the patients involved, the transfer can be of little value to such patients unless they are notified by either the estate or the physician receiving the records. This would seem to raise ethical implications as it could easily result in solicitation of patients, directly or indirectly.

There is no legal obstacle to the transfer of records to the patients themselves. However, such procedure raises professional questions as it is not advisable in many instances for patients to have access to a physician's records because of the danger of misunderstanding, misinterpretation or hysteria.

Therefore, it would seem wise for estates to pursue the following procedure in disposing of a physician's records:

Destroy the records of deceased patients after they have been retained possibly until the time has elapsed within which suit for malpractice may be instituted or until their value in connection with unpaid bills has ceased to exist.

With respect to records of patients still alive, send a brief notice to such patients, or their parents or guardians, advising of the physician's death and stating that the records of the deceased physician will be destroyed after a stated period unless a request is received asking that they be transferred to another attending physician.

Physicians might consider leaving instructions along these lines in their files. In doing so they would be performing a valuable, final service to their patients.





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# In Memoriam

George Edward Follansbee, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1895; aged 74; member of the Ohio State Medical Association; Fellow of the American Medical Association; former Fellow of the American College of Surgeons; diplomate, American Board of Surgery; died Jan. 1. Until his retirement about two years ago, Dr. Follansbee was one of Cleveland's most distinguished surgeons. He had been chief surgeon for the American Steel and Wire Company and the Grasselli Chemical Company, and chief of staff of St. Alexis Hospital. Nationally recognized as an authority on medical ethics, Dr. Follansbee was a member of the Judicial Council of the American Medical Association for 15 years, and had been chairman of the Council. He was President of the Ohio State Medical Association in 1924-1925, and had represented the Association in the House of Delegates of the A.M.A. While a member of the Council and President of the Cleveland Academy of Medicine and as President of the Cleveland Hospital Council and the Cleveland Medical Library Association, Dr. Follansbee rendered outstanding service in behalf of the medical profession, and in 1940 he was made an honorary member of the Academy as a token of the esteem in which he was held by the profession. He was also awarded the distinguished service certificate of the Cleveland Community Fund. Dr. Follansbee represented private practice on the Committee on the Costs of Medical Care, and later as a member of the Executive Committee wrote the minority report. His hobby was the history of explorations and he was an authority on the early explorations of North-eastern America. Surviving are his widow and a sister.

\* \* \*

George Emerson Cowles, M.D., Ostrander; Columbus Medical College, 1889; age 83; member of the Ohio State Medical Association and the American Medical Association; died Dec. 14. Delaware County's oldest active physician, Dr. Cowles practiced in Ostrander for 55 years. He was a member of the Baptist Church. His son, Dr. D. S. Cowles, Ostrander, a sister and a brother survive.

Stephen Andrew DeMartini, M.D., Cleveland; College of Physicians and Surgeons of Baltimore, Md., 1915; aged 58; Fellow of the American Medical Association; died Dec. 23. Dr. DeMartini had been senior surgeon at the U.S. Marine Hospital, Cleveland, for nine years. His widow and a brother survive.

Oscar Henry Henninger, M.D., Ironton; Pulte Medical College, Cincinnati, 1909; aged 59; member of the Ohio State Medical Association and the American Medical Association; died Dec. 21. In addition to an active professional career in Lawrence County for 35 years, Dr. Henninger had been a leader in community affairs. He was a member of the City Council and police judge for eight years. A captain in the Medical Corps overseas during World War I, Dr. Henninger was interested in veterans' affairs, was a member of the local post of the American Legion and one of the organizers of the Ironton chapter of the Disabled American Veterans. He was a former president of the Lawrence County Medical Society and a member of the County Hospital Board. Dr. Henninger was a member of the Masonic Lodge, the B.P.O.E., and the Eagles. He was an active outdoor sports follower and a member of the Lawrence County Conservation Association. Two daughters and a sister survive.

William Olney Jenks, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1874; aged 96; died Jan. 9. After practicing in Cleveland and vicinity for 60 years, Dr. Jenks retired ten years ago. A daughter and a son survive.

Gustav A. Hermann, M.D., Hamilton; University of Pittsburgh School of Medicine, 1896; aged 81; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 7. During the 42 years in which Dr. Hermann practiced in Hamilton, he maintained an active interest in community affairs. He had been a member of the local Board of Education and the Chamber of Commerce. A talented musician, he spent much of his leisure time in the enjoyment of music. Dr. Hermann was a member of the Evangelical Church and the Masonic Order. Surviving are his daughter and three sisters.

Ellis W. Kelly, M.D., Toledo; Toledo Medical College, 1897; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died Dec. 19. A general practitioner in Toledo since 1920, Dr. Kelly previously practiced in Temperance, Mich. He was a member of the staffs of St. Vincent's, Flower, Women's and Children's, and Toledo Hospitals. Dr. Kelly was a Mason. His widow, a son and a daughter survive.

Bertram Oliver Kreilick, M.D., Fremont; Ohio Medical University, Columbus, 1907; aged 62; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 30. A practicing physician in Fremont since 1908, Dr. Kreilick had been a member of the local Board of Education for 22 years, and its





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president for 19 years. He was a member of the staff of Memorial Hospital. Surviving are his widow, two daughters and a sister.

Albert George Kreimer, M.D., Cincinnati; University of Cincinnati College of Medicine, 1922; aged 51; member of the Ohio State Medical Association and the American Medical Association; died Dec. 22. Dr. Kreimer practiced in Hyde Park for over 20 years. His mother survives.

Frank John Kuta, M.D., Cleveland, University of Wooster, Medical Department, Cleveland, 1907; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died Dec. 14. A leader of the Polish community in Cleveland, Dr. Kuta had practiced on the Southside there for 37 years. He was one of the organizers of the Polish Chamber of Commerce and the Polish Medical and Dental Arts Club. Dr. Kuta was a member of the Catholic Church. Surviving are his widow, two daughters and two sons.

Verlando Ziegler Miller, M.D., Brookville; Starling Medical College, Columbus, 1896; aged 84; died Dec. 23. Dr. Miller practiced in Brookville for 45 years. His widow, three sons and six brothers survive.

Alvin Frank Renneker, M.D., Cincinnati; University of Cincinnati College of Medicine, 1911; aged 58; member of the Ohio State Medical Association and the American Medical Association; died Jan. 5. Dr. Renneker practiced in Cincinnati for over 30 years. Surviving are his widow, a son and a daughter.

Ulysses S. Leroy Shirkey, M.D., Cleveland; Columbus Medical College, Columbus, 1891; aged 83; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 8. An active general practitioner for 53 years, Dr. Shirkey practiced in Tiffin for one year before locating in Cleveland. His favorite pastime was cultivation of his flower garden. Dr. Shirkey was a member of the Masonic Order. His daughter survives.

Walter Addison Strayer, M.D., Glenshaw, Pa., Jefferson Medical College, Philadelphia, Pa., 1903; aged 67; former member of the Ohio State Medical Association and the American Medical Association, died Nov. 23. Formerly in practice in Mingo Junction and Steubenville, Dr. Strayer located in Glenshaw, Pa., in 1921. He was a member of the Masonic Order and the Elks Lodge. He is survived by six sisters.

Walter Boivin Taylor, M.D., Pickerington; Ohio Medical University, Columbus, 1902; aged 68; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 31. For more than 40 years a busy

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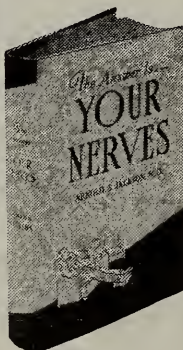
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general practitioner in northern Fairfield County, Dr. Taylor was active also in civic and fraternal associations. He was a former president of the Fairfield County Medical Society; president of the Pickerington Bank and active in obtaining a Carnegie Library for Pickerington. Surviving are his wife; two sons, including Dr. K. W. Taylor, Pickerington; his mother, a brother and three sisters.

Della Mary Walker, M.D., Salem; Woman's Medical College of Pennsylvania, Philadelphia, 1894; aged 81; died Dec. 24. A practicing physician in Salem for many years, Dr. Walker had been in ill health for 18 months. She was a member of the Presbyterian Church.

Herman W. Weinberg, M.D., Youngstown; University of Pennsylvania School of Medicine, Philadelphia, 1900; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died Dec. 31. Dr. Weinberg retired a year ago because of ill health, after practicing in Youngstown for over 40 years. He was a member of the Masonic Order. His widow, a son, three sisters and a brother survive.

Simon B. Winters, M.D., Briggsdale; Columbus Medical College, 1892; aged 79; member of the Ohio State Medical Association and the American Medical Association; died Jan. 8. A practicing physician in Briggsdale for the past 45 years, Dr. Winters was a former president of the Columbus General Practitioners' Association and a member of the Board of Trustees of Mercy Hospital, Columbus. He was a member of the Masonic Order. Surviving are his widow, three sons and a sister.

Medical Meetings Cancelled

The Second Annual Clinical Conference of the Chicago Medical Society scheduled to be held at the Palmer House, Chicago, Feb. 27 to March 1, has been cancelled in accordance with the request of the War Committee on Conventions of the Office of Defense Transportation that no such meetings involving an attendance of more than 50 persons be held after Feb. 1.

The American College of Surgeons has deferred for the time being its 1945 series of War Sessions, one of which was to have been held at Cleveland on Feb. 27.

Another meeting called off is the Midwest Conference on Rehabilitation, sponsored by the Institute of Medicine of Chicago, which was scheduled for Chicago, Feb. 12.

Columbus—Dr. Russell G. Means is chairman of a 22-member health committee planning to improve Columbus's wartime health. The city has been entered in the 1945 health conservation contest of the National Health Honor Roll by the local Chamber of Commerce.

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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### ADAMS

Officers for the Adams County Medical Society for 1945 are: Dr. Robert B. Ellison, Peebles, pres.; Dr. Robert L. Lawwill, Seaman, vice-pres.; Dr. Hazel L. Sproull, West Union, secretary-treasurer; Dr. Samuel C. Clark, Cherry Fork, chmn., Legislative Committee.

### BUTLER

Dr. Harry H. Haggart, Cincinnati, spoke on "Plastic and Reconstructive Surgery of the Face", at a meeting of the Butler County Medical Society, Dec. 21, at Mercy Hospital, Hamilton.—Azel Ames, M.D., president.

### CLERMONT

Officers of the Clermont County Medical Society for 1945 are: Dr. Arthur B. Ream, Batavia, pres.; Dr. Pearl Zeek Minning, Williamsburg, vice-pres.; Dr. J. M. Coleman, Loveland, secy.-treas.; Dr. Allen B. Rapp, Owensville, chmn., Legislative Committee and Committee on Public Relations.

Members of the society were dinner-guests of Dr. and Mrs. F. S. Skeen at their home in Batavia on the evening of Nov. 15. Dr. Skeen was president of the society in 1944. The guest speaker was Dr. Parke G. Smith, Cincinnati, who discussed "Newer Treatments for Cancer of the Prostate".—News clipping.

### CLINTON

Capt. George M. Wilcoxon, Alliance, flight surgeon at the Clinton County Army Air Field, spoke on "World War II Casualties", at a meeting of the Clinton County Medical Society, Jan. 2, at the General Denver Hotel, Wilmington.—R. W. DeCrow, M.D., secretary.

### HAMILTON

The following programs were presented by the Academy of Medicine of Cincinnati during January:

Jan. 2—In cooperation with the Cincinnati Health Department.—"The Relations Between the Health Department and the Doctor", Dr. Otto Engelke, director, Washtenaw County Health Dept., Ann Arbor, Mich., and formerly health commissioner of Adams County, Ohio; "Reporting Rheumatic Heart Disease", Dr. Bernard Schwartz; "The Tuberculosis Program", Dr. Carl A. Wilzbach, health commissioner of Cincinnati.

Jan. 16-17—The 1945 B. K. Rachford Lecture series. General subject—The Rheumatic Problem. 1. "The Present Status". 2. "Approaches Awaiting Development", Lieut. Comdr. Alvin F. Coburn, M.C., U.S.N.R., assistant professor of medicine, Columbia University, New York.—Bulletin.

## HIGHLAND

The following Hillsboro physicians are the officers of the Highland County Medical Society for 1945: Dr. J. C. Larkin, pres.; Dr. J. D. McBride, vice-pres.; Dr. W. B. Roads, secy.-treas.; Dr. Larkin, chmn., Legislative Committee; Dr. McBride, chmn., Committee on War Participation.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### CHAMPAIGN

Officers of the Champaign County Medical Society for 1945 are the following Urbana physicians: Dr. E. R. Earle, pres.; Dr. Vogt G. Wolfe, pres.-elect.; Dr. Ansel Woodburn, secy.-treas.; Dr. D. C. Houser, chmn., Legislative Committee; Dr. Mark Houston, chmn., Committee on War Participation.

### GREENE

A film entitled "Allergy" was shown through the courtesy of Mead Johnson and Company, at a meeting of the Greene County Medical Society, Jan. 4, at Xenia. Dr. Jack Tepper led the discussion which followed.—Nancy E. Lautzenheiser, M.D., secretary.

The society's officers for 1945 are: Dr. Donald F. Kyle, Cedarville, pres.; Dr. Harold E. Ray, Xenia, vice-pres.; Dr. Nancy E. Lautzenheiser, Xenia, secy.-treas.; Dr. F. M. Chambliss, Xenia, chmn., Legislative Committee.

### MIAMI

Dr. John Judy, Dayton, spoke on "Some Mechanical Methods of Fracture Care", at a meeting of the Miami County Medical Society, Jan. 5, at Memorial Hosp., Piqua.—G. A. Woodhouse, M.D., secretary.

### MONTGOMERY

The following Dayton physicians are the officers of the Montgomery County Medical Society for 1945: Dr. C. J. Derby, pres.; Dr. Norman C. Hochwalt, vice-pres.; Dr. R. E. Boswell, secy.; Dr. A. D. Cook, treas.; Dr. R. K. Finley, chmn., Legislative Committee; Dr. Curtiss Ginn, chmn., Committee on War Participation; Dr. F. G. Barr, chmn., Committee on Industrial Health; Dr. N. E. Leyda, chmn., Committee on Recreation and Physical Fitness.—Marie T. Yoder, executive secretary.

Dr. Robert L. Crudgington, assistant professor of obstetrics, University of Cincinnati College of Medicine, spoke on "Obstetrics for the General Practitioner", at a meeting of the society, Jan. 5, in the Fidelity Building Auditorium, Dayton.—Bulletin.



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### Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

#### AUGLAIZE

At a meeting of the Auglaize County Medical Society, Dec. 14, at Minster, Dr. James O. Beavis, Dayton, spoke on "Reconstructive Measures for the Cleft of Lip and Palate". Dr. Margaret E. Belt, Lima, discussed "Pediatric Care of Babies with Cleft Lip and Palate".—E. A. Gomolski, M.D., secretary.

Officers of the society for 1945 are: Dr. T. H. Will, Minster, pres.; Dr. Alfred Veit, Wapakoneta, vice-pres.; Dr. E. A. Gomolski, Minster, secy.-treas.; Dr. Guy E. Noble, St. Marys, chmn., Legislative Committee; Dr. Geo. B. Faulder, chmn., Committee on War Participation; Dr. Roy C. Hunter, Wapakoneta, chmn., Committee on Industrial Health; Dr. W. V. Barton, St. Marys, chmn., Committee on Recreation and Physical Fitness.

#### CRAWFORD

Dr. L. H. Huffman, Cleveland, spoke on "Common Urological Errors", at a dinner meeting of the Crawford County Medical Society, Dec. 4, at Green Lawn Inn, Galion. The following new officers were elected: Dr. F. W. Kehrer, Bucyrus, pres.; Dr. D. D. Bibler, Bucyrus, vice-pres.; Dr. J. W. Arnold, Bucyrus, secy.-treas.; Dr. C. A. Marquart, Crestline, chmn., Legislative Committee; Dr. Mart Helfrich, Galion, chmn., Committee on War Participation; Dr. Bibler, chmn., Committee on Recreation and Physical Fitness.—Clarence Adams, M.D., retiring secretary.

#### HARDIN

Officers of the Hardin County Medical Society for 1945 are: Dr. H. E. Gibson, Kenton, pres.; Dr. F. M. Elliott, Ada, vice-pres.; Dr. R. H. Zeis, Kenton, secy.-treas.; Dr. Elliott, chmn., Legislative Committee and Committee on War Participation; Dr. R. G. Schutte, Kenton, chmn., Committee on Industrial Health; Dr. C. L. Johnson, Kenton, chmn., Committee on Recreation and Physical Fitness.

#### MARION

"Sterility", was the topic discussed by Dr. Wynne M. Silbernagel, Columbus, at a meeting of the Marion Academy of Medicine, Jan. 2, at the Marion City Hospital. The following new officers were installed: Dr. John A. McNamara, pres.; Dr. Richard L. Morgan, vice-pres.; Dr. H. K. Mouser, secy.-treas.; Dr. Thos. H. Sutherland, chmn., Legislative Committee; Dr. Frank L. Thomas, chmn., Committee on War Participation; Dr. Jack F. Smyth, chmn., Committee on Industrial Health; Dr. D. W. Brickley, Sr., chmn., Committee on Recreation and Physical Fitness.

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## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### DEFIANCE

Officers of the Defiance County Medical Society for 1945 are: Dr. Geo. DeMuth, Sherwood, pres.; Dr. Paul B. Newcomb, Defiance, vice-pres.; Dr. E. P. Mitchell, Defiance, secy.-treas.; Dr. DeMuth, chmn., Legislative Committee; Dr. Mitchell, chmn., Committee on Industrial Health.

### HENRY

The following Napoleon physicians are officers of the Henry County Medical Society for 1945: Dr. J. J. Harrison, pres.; Dr. Thomas Quinn, vice-pres.; Dr. J. R. Bolles, secy.-treas., and chmn., Legislative Committee; Dr. R. L. Gilson, chmn., Committee on War Participation.

### LUCAS

The Toledo Academy of Medicine presented the following programs during January:

Jan. 5—Forty-Third Annual Meeting of the Academy. "The Home Front Doctor in the Rehabilitation of the Disabled Veteran", Dr. C. D. Selby, medical director, General Motors Corporation, Detroit, Mich.

Jan. 12—Section of Pathology, Experimental Medicine and Bacteriology. "Fear in Cardiology Practice", Dr. F. C. Clifford.

Jan. 19—Medical Section. "Interpreting Serologic Reactions", Reuben L. Kahn, Sc.D., director of laboratories, University Hospital, and assistant professor of bacteriology, University of Michigan.

Jan. 26—Surgical Section. A Symposium on "Surgical Errors", Drs. C. W. McNamara, O. W. Burkholder, J. I. Collins and H. P. Shapiro.—Bulletin.

### WILLIAMS

The following officers of the Williams County Medical Society were re-elected to serve in 1945: Dr. H. R. Mayberry, Bryan, pres.; Dr. M. R. Kittredge, Bryan, vice-pres.; Dr. H. J. Luxan, Montpelier, secy.; Dr. H. L. Prouty, West Unity, chmn., Legislative Committee; Dr. Luxan, chmn., Committee on War Participation.

## Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

### CUYAHOGA

At a meeting of the Internal Medicine Section of the Academy of Medicine of Cleveland, Jan. 31, the following program was presented: "The Use of Heparin and Dicoumarin in Peripheral Thrombophlebitis", Dr. Lawrence Atlas; "Relationship of Vitamin K and Dicoumarin to Blood Clotting", Dr. Robert W. Heinle.—Bulletin.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### PORTAGE

Dr. W. V. Collier, pathologist at St. Elizabeth's Hospital, Youngstown, spoke on "The Rh

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Factor", at a meeting of the Portage County Medical Society, Jan. 4, at Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

#### SUMMIT

"The Professional Relationships of Industrial Medicine", was the topic discussed by Dr. C. D. Selby, medical consultant, General Motors Corporation, Detroit, at a meeting of the Summit County Medical Society, Jan. 9, at Akron City Hospital.—Bulletin.

Officers of the society for 1945 are: Dr. J. M. Ulrich, pres.; Dr. R. A. Gregg, pres.-elect; Dr. R. M. Lemmon, secy.; Dr. C. E. Held, treas.; Dr. R. E. Pinkerton, chmn., Legislative Committee; Dr. W. A. Hoyt, chmn., Committee on War Participation; Dr. D. M. McDonald, chmn., Committee on Industrial Health; Dr. R. F. Jolley, chmn., Committee on Public Relations and Medical Economics.—Jean Hagstrom, office secretary.

#### Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

##### CARROLL

Officers of the Carroll County Medical Society for 1945 are: Dr. Glenn C. Dowell, Carrollton, pres.; Dr. W. G. Lyle, Minerva, vice-pres.; Dr. P. S. Whiteleather, Minerva, secy.-treas.; Dr. J. H. Murray, Carrollton, chmn., Legislative Committee; Dr. Carl A. Lincke, Carrollton, chmn., Committee on War Participation; Dr. Dowell, chmn., Committee on Industrial Health; Dr. Jos. D. Stires, Malvern, chmn., Committee on Recreation and Physical Fitness.

##### COSHOCTON

The Coshocton County Medical Society has elected the following officers for 1945: Dr. H. H. Schwindt, West Lafayette, pres.; Dr. R. E. Hopkins, Coshocton, vice-pres.; Dr. H. W. Lear, Coshocton, secy.-treas.; Dr. G. A. Foster, Coshocton, chmn., Legislative Committee.

##### HARRISON

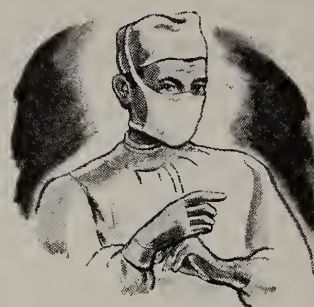
Officers of the Harrison County Medical Society for 1945 are: Dr. Dwight C. Pettay, Cadiz, pres.; Dr. G. E. Henderson, New Athens, vice-pres.; Dr. Carl F. Goll, Hopedale, secy.-treas.; Dr. E. L. Miller, Bowerston, chmn., Legislative Committee; Dr. J. M. Scott, Scio, chmn., Committee on War Participation; Dr. J. P. Fairchild, Freeport, Chmn., Committee on Industrial Health and Committee on Recreation and Physical Fitness.

#### Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

##### ATHENS

Dr. H. T. Phillips, health commissioner of Athens County, discussed the aims of the Health Department and means of cooperation between the department and practicing physicians, at a

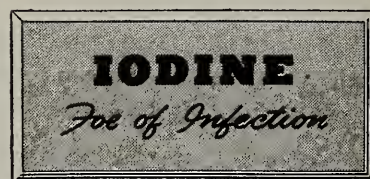


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meeting of the Athens County Medical Society, Dec. 14, in the Nelsonville Presbyterian Church.—News clipping.

#### GUERNSEY

Officers of the Guernsey County Medical Society for 1945 are: Dr. F. C. Huth, Cambridge, pres.; Dr. J. E. Patton, Cambridge, vice-pres.; Dr. M. S. Lawrence, Quaker City, secy.-treas.

#### MUSKINGUM

"Treatment of Malignancies", was the subject of an address made by Dr. Charles F. Bowen, Columbus, at a meeting of the Muskingum County Academy of Medicine, Jan. 3, at the Zanesville University Club.—Beatrice T. Hagen, M.D., secretary.

#### WASHINGTON

Officers of the Washington County Medical Society for 1945 are: Dr. W. E. Radcliff, Caldwell, pres.; Dr. E. W. Hill, Jr., Marietta, vice-pres.; and Dr. V. H. Goodrich, Marietta, secy.-treas.

### Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

#### PIKE

The Pike County Medical Society has elected the following officers for 1945: Dr. W. L. McCaleb, Beaver, pres.; Dr. Robert T. Leever, Waverly, vice-pres.; Dr. L. E. Wills, Waverly, secy.-treas.; Dr. Mack E. Moore, Piketon, chmn., Legislative Committee.

#### SCIOTO

Members of the Hempstead Academy of Medicine were hosts to their wives at a turkey dinner and Christmas party, Dec. 11, at the American Legion Home, Portsmouth, with about 80 persons present. Following a program of music, Frank Harris, Greenfield, a world-wide traveler, spoke on "Mexico".

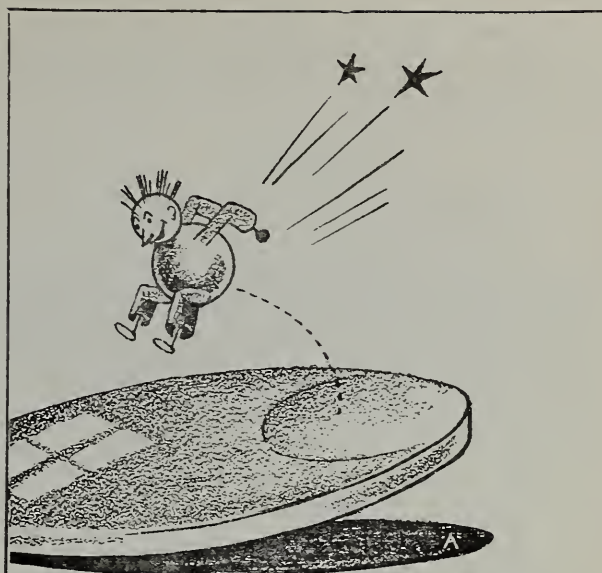
The Academy elected the following officers for 1945: Dr. W. C. McCann, Minford, pres.; Dr. George D. Blume, New Boston, vice-pres.; Dr. T. W. Frame, Portsmouth, secy.-treas.; Dr. Joseph S. Rardin, Portsmouth, chmn., Legislative Committee; Dr. Harry T. Rapp, Portsmouth, chmn., Committee on War Participation; Dr. C. L. Ferguson, Portsmouth, chmn., Committee on Industrial Health; Dr. Clyde M. Fitch, Portsmouth, chmn., Committee on Recreation and Physical Fitness.

### Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

#### DELAWARE

Officers of the Delaware County Medical Society for 1945 are: Dr. James G. Parker, Delaware, pres.; Dr. Bernard R. Lauer, Delaware, vice-pres.; Dr. F. M. Stratton, Delaware, secy.-treas.; Dr. M. S. Cherington, Delaware, chmn., Legislative Committee and Committee on Indus-



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trial Health; Dr. F. V. Miller, Delaware, chmn., Committee on War Participation; Dr. H. W. Davis, Ashley, chmn., Committee on Recreation and Physical Fitness.

#### FRANKLIN

The Columbus Academy of Medicine presented the following programs during January:

Jan. 8—"Sinusitis, Bronchitis and Bronchiectasis", by Dr. William J. Miller and Dr. Karl P. Klassen.

Jan. 22—"The Functional Consequences of Coronary Occlusion", Dr. Carl J. Wiggers, professor of physiology, Western Reserve University School of Medicine; discussion by Dr. George I. Nelson.—Bulletin.

#### KNOX

The Knox County Medical Society has elected the following officers for 1945: Dr. E. V. Ackerman, Fredericktown, pres.; Dr. Chas. S. Baldwin, Centerburg, vice-pres.; Dr. Pauline Freeman, Danville, secy.-treas.; Dr. Carroll D. Conard, Mt. Vernon, chmn., Legislative Committee; Dr. Julius Shamansky, Mt. Vernon, chmn., Committee on War Participation; Dr. James F. Lee, Mt. Vernon, chmn., Committee on Industrial Health and Committee on Recreation and Physical Fitness.

#### ROSS

Officers of the Ross County Academy of Medicine for 1945 are: Dr. E. Paul Shepard, pres.; Dr. M. D. Scholl, vice-pres.; Dr. Ralph W. Holmes, secy.-treas.; Dr. Loy E. Hoyt, chmn., Legislative Committee and Committee on War Participation; Dr. Scholl, chmn., Committee on Industrial Health—all of Chillicothe, and Dr. W. B. Smith, Frankfort, chmn., Committee on Recreation and Physical Fitness.

### Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

#### ASHLAND

The following Ashland physicians have been elected officers of the Ashland County Medical Society for 1945: Dr. E. L. Clem, pres.; Dr. L. G. Sheets, vice-pres.; Dr. R. P. Bogniard, secy.-treas.; Dr. L. H. Martin, chmn., Legislative Committee; Dr. C. B. Meuser, chmn., Committee on War Participation; Dr. Sheets, chmn., Committee on Industrial Health; Dr. Meuser, chmn., Committee on Recreation and Physical Fitness.

#### ERIE

Officers of the Erie County Medical Society for 1945 are the following Sandusky physicians: Dr. William Burger, pres.; Dr. William Fenker, vice-pres.; Dr. E. J. Meckstroth, secy.-treas.

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**HOLMES**

Officers of the Holmes County Medical Society for 1945 are: Dr. N. P. Stauffer, Killbuck, pres.; Dr. J. C. Elder, Millersburg, vice-pres.; Dr. A. J. Earney, Millersburg, secy.-treas.; Dr. A. T. Cole, Millersburg, chmn., Legislative Committee, Committee on War Participation and Committee on Industrial Health; Dr. Elder, chmn., Committee on Recreation and Physical Fitness.

**HURON**

Members of the Huron County Medical Society have elected the following officers for 1945: Dr. C. B. Thomas, Norwalk, pres.; Dr. R. A. Blackman, Norwalk, vice-pres.; Dr. George F. Linn, Norwalk, secy.-treas.; Dr. H. A. Erlenbach, New London, chmn., Committee on War Participation; Dr. W. W. Lawrence, Norwalk, chmn., Committee on Industrial Health; Dr. James M. Hindley, Monroeville, chmn., Committee on Recreation and Physical Fitness.

**LORAIN**

Dr. Robert Dinsmore, Cleveland, spoke on "Tumors of the Neck", at a meeting of the Lorain County Medical Society, Jan. 9, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

**WAYNE**

Officers of the Wayne County Medical Society for 1945 are: Dr. George H. Irvin, Orrville, pres.; Dr. John B. Beeson, Wooster, vice-pres.; Dr. R. C. Paul, Wooster, secy.-treas.; Dr. O. P. Ulrich, Orrville, chmn., Legislative Committee; Dr. Paul, chmn., Committee on War Participation.

**WOMAN'S AUXILIARY NEWS**

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

**FRANKLIN**

The Woman's Auxiliary to the Columbus Academy of Medicine presented the following programs since Fall. The October meeting was a tea held at the home of Mrs. William Millhon in Upper Arlington. It was a get-acquainted affair and many members attended. In November, the regular meeting was held at the Columbus Gallery of Fine Arts. Pictures of Central America and Mexico were shown, with musical accompaniment. Refreshments were served to the members

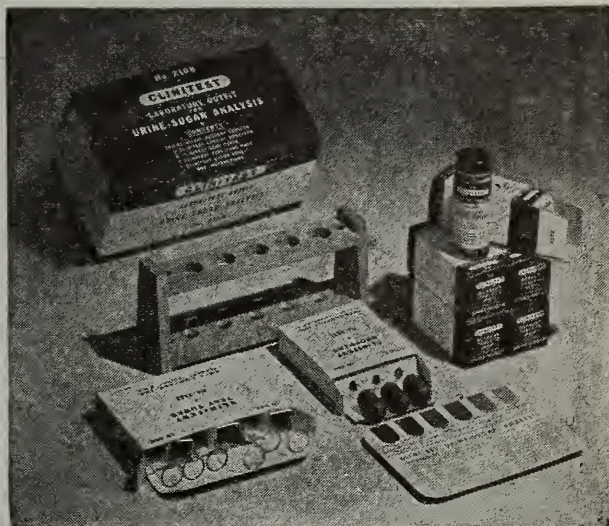
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and to the doctors who met at the Gallery the same evening. In December, a joint Christmas party was held with members of the Academy.

#### HAMILTON

The Woman's Auxiliary to the Academy of Medicine of Cincinnati has presented the following programs: Three forum meetings, with speakers and general discussion have been highly successful. In October, "Juvenile Delinquency" was the topic, and in November, "Health in Our Schools". A festive Christmas tea was enjoyed by the members in December. The January meeting consisted of a forum discussion of "Global Medicine", with a special speaker from Ft. Thomas, Kentucky.

#### KNOX

Mrs. Julius Shamansky and Mrs. Richard Gomer were co-hostesses to the members of the Woman's Auxiliary to the Knox County Medical Society, Wednesday evening, Jan. 3, at the home of the former in Mt. Vernon. During the business session it was reported that hospital guilds are being organized to sew for the local hospitals. Mrs. Shamansky was named general chairman; Mrs. James F. Lee, chairman of the Mercy Hospital group, and Mrs. J. M. Pumphrey, to head the group of the Mount Vernon Hospital-Sanitarium.

#### MARION

The members of the Woman's Auxiliary to the Marion Academy of Medicine were guests of Mrs. Filmore Young at a lovely Christmas party. During the afternoon members filled gift handkerchiefs to be presented to service men passing through the city on Christmas day. Mrs. J. A. Dodd presided at a brief business session, after which refreshments were served from a perfectly appointed tea table.

#### ROSS

Mrs. H. M. Crumley opened her home in Chillicothe, Dec. 7, to the members of the Auxiliary for an interesting Christmas party. Fifteen members were present. A gift exchange and bridge highlighted the evening's entertainment.

On January 4, the Auxiliary members enjoyed dinner at Allyn's Dining Room, followed by a program and business meeting at the Y.M.C.A. Mr. Laurence Landis, guest speaker, related many interesting things about Australia. He was stationed there for 14 months as supply officer with the Army Exchange Service. At the business meeting plans were formulated to raise funds to purchase an incubator for the Chillicothe hospital. A rummage sale sponsored by all the members, and a series of bridge parties given in the homes of each member, are being arranged to raise the funds. Mrs. Howard E. Harmon, a new member, was welcomed to the Auxiliary. Mrs. Nicholas Holmes was a guest.

#### SCIOTO

The annual Christmas party of the Woman's Auxiliary to the Hempstead Academy of Medicine was held at the home of Mrs. Clyde Fitch, Portsmouth, Dec. 6, with 39 members and one guest, Mrs. I. P. Seiler, Piketon, present. Mrs. Mack Moore, Piketon, and Mrs. Robert Leever, Waverly, were welcomed as associate members.

Mrs. W. A. Braunlin reported that Christmas cards had been sent by the Auxiliary to Scioto County physicians in the service. Mrs. Clyde Fitch stated that \$5,000 in war bonds had been sold during the Sixth War Loan Drive. The following contributions were approved: Purchase of a \$5 Christmas Seal Bond; donation of \$5 to the crippled children's class; \$10 for the Salvation Army; and \$10 for the Scioto County Children's Home. Mrs. W. E. Gault gave a review of "The Christmas Tree Legend". During the social hour refreshments were served and a passing party enjoyed.

Judge Emory Smith spoke on "Juvenile Delinquency", at a meeting of the Auxiliary, Jan. 10, at the home of Mrs. George Obrist. Mrs. C. W. Wendelken gave a report on the group's gifts to the county home and Mrs. Carl Braunlin told of gifts to the American Legion and disabled war veterans. Mrs. Clyde Fitch spoke about *Hygeia*, the health magazine of the American Medical Association.

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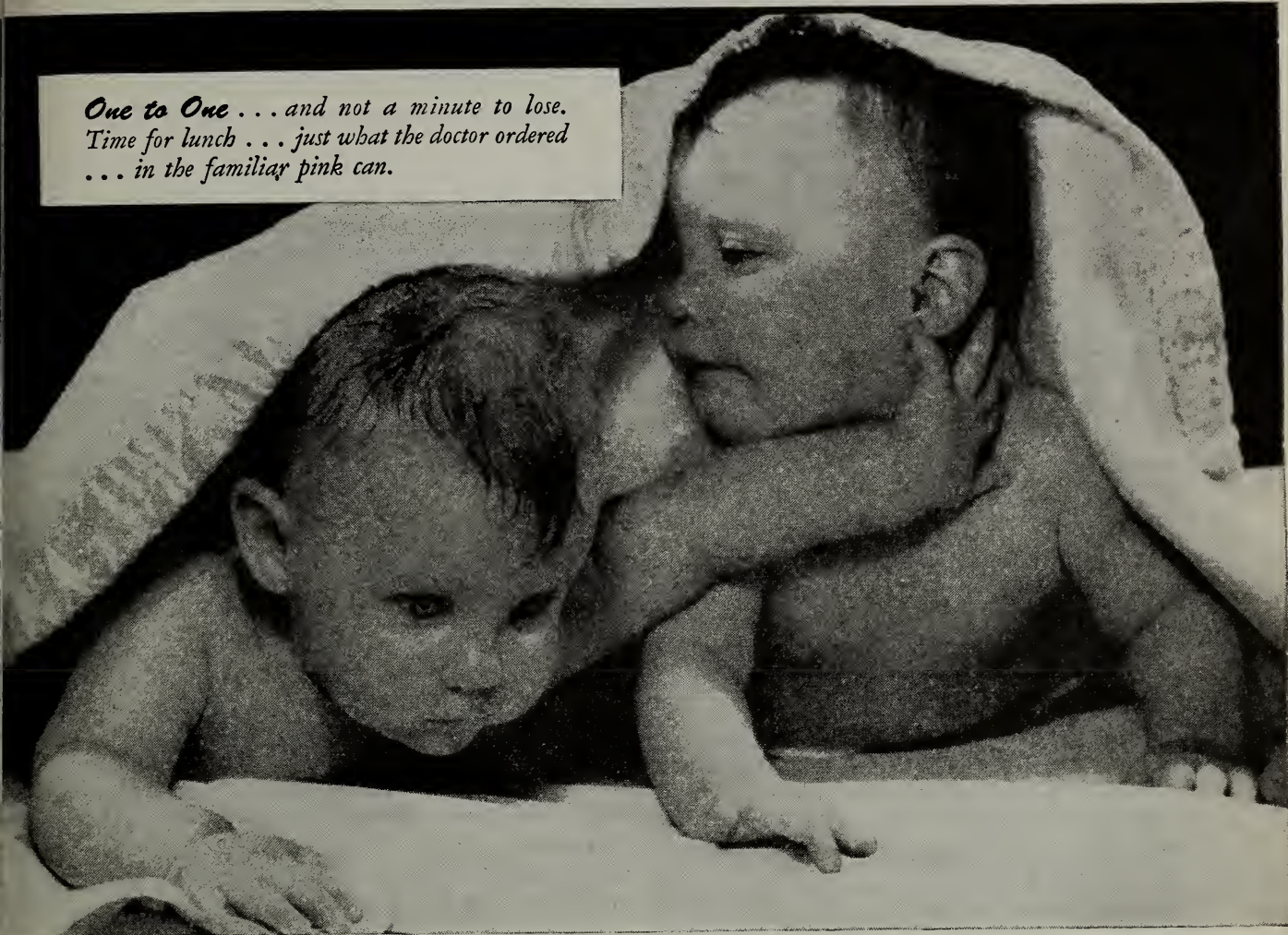
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# The Physician's Bookshelf

**The Embryology of Behavior**, by Arnold Gesell, M.D., in collaboration with Catherine S. Amatruda, M.D., (\$5.00. *Harper & Brothers, New York City*) tells the story of the beginnings of the human mind. It presents much new data gleaned from the study of a group of premature infants. It is a real contribution to foundations of psychosomatic medicine.

**Arterial Hypertension: Its Diagnosis and Treatment**, by Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D. (\$3.75. *The Year Book Publishers, Chicago*) is intended as a useful manual for the care of the victim of this disturbance. It is written by the two well known students of the subject to mark their moving from Lilly Laboratory for Clinical Research to the Research Division of the Cleveland Clinic. It is very much worth owning.

**The Avitaminoses**, by Walter H. Eddy, Ph.D., and Gilbert Dalldorf, M.D. (\$4.50. 3rd Ed. *The Williams & Wilkins Co., Baltimore*) correlates clinical observation, on pathological examination, and biochemical investigations. In this way, the whole subject of vitamins is covered.

**Life Overflows**, by Carl Leonard Thenebe, M.D., (\$2.50. *Bruce Humphries, Inc., Boston*) is an original scrapbook arrangement of soothing philosophical thoughts. This Connecticut physician has done a helpful bit for the bedsick.

**The Civilized Diseases: You Can Cure Them**, by Boris F. Sokoloff, M.D., (\$2.00. *Howell, Soskin & Co., New York City*) gives information and advice on heart disease, high blood pressure, diabetes, kidney diseases, arthritis, asthma, cancer, constipation, anemia, and eye trouble. In asthma, great emphasis is placed on adrenal cortex and Vitamin C.

**The Etiology, Diagnosis, and Treatment of Amebiasis**, by Charles Franklin Craig, M.D., (\$4.50. *The Williams & Wilkins Co., Baltimore*) covers every phase of the subject in a clear, concise manner. It will make an excellent reference book which we shall all need as the infestation flares up in our returned soldiers and sailors.

**Clinical Heart Disease**, by Samuel A. Levine, M.D., (\$6.00. 3rd Ed. *W. B. Saunders Co., Philadelphia*) is a manual on heart disease meant to appeal to the family physician. It has been kindly received by them so now it is brought up to date.

**Symptoms of Visceral Disease**, by Francis M. Pottenger, M.D., (\$5.00. 6th Ed. *The C. V. Mosby Co., St. Louis*) presents another revision of the author's study of the Vegetative Nervous System in its Relation to Clinical Medicine. It is a book that every physician needs for it tries

to bridge the gap from our examining room to the physiology.

**Physical Growth and Development**, by Katherine Simmons. A Brush Foundation Study, (\$1.25. Vol. IX, Serial 37, No. 1. *Monograph of the Society for Research in Child Development*) brings up to date much of the tabular material of the studies initiated by the late Dr. T. Wingate Todd.

**Family Food Consumption in the United States, Spring, 1942.** (Miscellaneous No. 550, U.S.D.A., 1944, (\$0.20 from *Supt. of Documents, U.S. Printing Office, Washington 25, D.C.*) shows a significant amount of improvement as compared with 1936 due to popular education, I should like to believe.

**The Story of Doctor King**, by Mary Wallace, (\$2.00. *The Commissariat of the Holy Land, Washington, D.C.*) is an engrossing novel of contemporary life—refreshingly idealistic.

**Atlas of the Blood in Children**, by Kenneth D. Blackfan, M.D., and Louis K. Diamond, M.D., (\$12.00. *The Commonwealth Fund, New York City*, presents pictures of the blood in children, illustrated by C. Merrill Leister, M.D. The volume will be of great service to students of blood and of the diseases of children.

**Lead Poisoning**, by Abraham Cantarow, M.D., and Max Trumper, Ph.D., (\$3.00. *The Williams & Wilkins Co., Baltimore*) brings us up to date on the most serious occupational hazard.

**Control of Pain in Childbirth**, by Clifford B. Lull, M.D., Robert A. Hingson, M.D., and Norris W. Vaux, M.D., (\$7.50. *J. B. Lippincott Co., Philadelphia*) condenses and summarizes an immense literature and correlates it all with the author's experience at the Philadelphia Lying-In Hospital of the Pennsylvania Hospital. It is up to the high standard of Lippincott selected professional books.

**Conserving Marriage and the Family**, by Ernest R. Groves (\$1.75. *The Macmillan Co., New York City*) is a realistic discussion of the divorce problem by this well known authority on family life. It should be placed in the hands of every one of your patients who is beginning to doubt the wisdom of going on with his marriage.

**The 1944 Year Book of General Medicine**, (\$3.00. *The Year Book Publishers, Inc., Chicago*) shows the effect of the war by emphasizing military and tropical medicine, as well as by the lack of articles to review on many medical topics. The work itself, however, is up to usual standard and does present well what there is to abstract and comment upon.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

March, 1945

No. 3

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## Acute Laryngo-Tracheo-Bronchitis\*

R. E. HOWARD, M.D.

THIS disease is an acute inflammation of the larynx, trachea, and bronchi generally starting as an upper respiratory infection and passing downward causing more serious complications as it progresses into the lower respiratory tract.

This disease should not be confused with membranous or spasmodic croup as seen in diphtheria and whooping cough, respectively, but is a definite serious clinical entity. The synonyms sometimes used are acute infectious croup, suffocative catarrh and subglottic edema.

### SYMPTOMS

Most of our cases gave a history of one or two days' slight upper respiratory infection followed by sudden respiratory distress, rapid pulse, elevation in temperature and general toxemia requiring sudden hospitalization. The rapid progress of the disease is typical, starting with a dry cough, and dyspnea, followed by marked retractions of supra-sternal and supra-clavicular spaces and epigastrium. The patient becomes extremely restless and has a pallor as seen in cases of air hunger and asphyxia.

### ETIOLOGY

In our series we found the hemolytic staphylococcus aureus as the predominating organism in twenty cases, while the hemolytic streptococcus was found in two cases and the pneumococcus Type 19 was present in the other two, cultured.

Almost all the pyogenic organisms have been reported according to various authors describing

### The Author

• Dr. Howard, Cincinnati, Ohio, is a graduate of the University of Cincinnati College of Medicine, 1927; president, League of Hard of Hearing; member, American Academy of Laryngology, Otolaryngology and Rhinology; attending otolaryngologist, Christ, Good Samaritan, Bethesda and Children's Hospitals; asst. prof. in otolaryngology and instructor in anatomy, University of Cincinnati College of Medicine.

this disease. It is most likely that these organisms described are secondary invaders and the primary infection is caused by a virus.

In two recent cases, M.S. and C.S., no improvement was noted until after whole blood from a donor convalescent from virus pneumonia was given and then almost immediate cessation of crusts, edema and toxic symptoms were noted.

Baum in 1936 expressed the opinion that the basic cause of laryngo-tracheo-bronchitis was the filterable virus of influenza and that his views were strengthened by results of treatment based on it. MacCready in his recent article also believes that H. Influenza Type B has caused their most seriously sick cases in New Haven, Conn.

Brighton in 1940 called attention to an almost identical disease in chickens—infectious laryngo-tracheitis. Beach has demonstrated in fowls that while many organisms can be found on culture of secretions, the actual cause is the filterable virus. A successful virus vaccine has been prepared for use against this disease in chickens. Thus Brighton concludes that human laryngo-

\*From the Department of Otolaryngology, College of Medicine, University of Cincinnati.

Presented before the Section on Eye, Ear, Nose and Throat, Ninety-Eighth Annual Meeting, Ohio State Medical Association, Columbus, May 2-4, 1944.

tracheo-bronchitis is similar, and results from a virus infection with secondary invaders.

**PATHOLOGY**

Dr. Chevalier Jackson described laryngo-tracheo-bronchitis as a descending mucositis occurring with first a stage of dry inflammation followed by congestion, edema and excessive secretion. Schiller considered the disease essentially a cellulitis of mucosa and submucosa with lymphangitis, edema, infiltration of white cells, focal necrosis and vascular changes.

The outstanding pathology of laryngo-tracheo-bronchitis as studied from our slides of post-mortem cases, and direct laryngoscopy, and bronchoscopy revealed an early edema of the mucosa and submucosa or larynx, with a later necrosis and desquamation of the mucosa forming the obstructive plugs and crusts in the tracheo-bronchial tree. These formations prevent the air from reaching the alveoli and thus embarrass the circulation. The laryngoscopic picture presents an intensely congested mucous membrane of the larynx with edema of the subglottic tissues barely admitting a small bronchoscope.

Through the bronchoscope one can see the red, edematous and velvety mucous membrane while the tracheal rings are obliterated. Occasionally one will see blood oozing from the mucosa.

Following tracheotomy the bronchoscope may be inserted in the trachea and the trachea-bronchial tree inspected for edema, secretions, plugs and crusts. Bronchial secretions are seen to be thick and tenacious tending to form strings of exudate across the lumen. Some orifices to the bronchi may be seen filled with pus and if free from bubbles this may mean no air is passing to and from the alveoli and that part of the lung

The fundamental therapy is to maintain an airway for the child and prevent progression of the disease. It has been pointed out by Baum of Denver that while an early tracheotomy saves the patient from exhausting effort of breathing through an obstructive channel, it unquestionably predisposes to later complications in the lower air passages. He states that though the laryngeal obstruction is relieved by tracheotomy 50 per cent of the patients go on and die from progression of the obstruction to the peripheral bronchi.

The secretions undoubtedly thicken and form plugs following tracheotomy and once removed, reform time and again. Eventually there is obstruction of the smaller bronchi and bronchioles which result in areas of atelectasis and sometimes broncho-pneumonia. Baum has always been very conservative and has often suggested intubation instead of tracheotomy as a way of preventing plug and crust formation.

I have not had any experience with this procedure in true laryngo-tracheo-bronchitis, but believe it is worthy of a trial in combination with the hypertonic plasma therapy.

Hypertonic plasma has already been used in treatment of shock, burns, cerebral and nephrotic edema. Rationale behind its use according to Baum is the osmotic action to withdraw the fluid of the swelling in the interstitial tissue spaces in the subglottic area, and the mucosa and submucosa of trachea and bronchi. The fluid is held in the blood stream then by the plasma.

The method of preparation of hypertonic plasma is to add only 60 to 85 c.c. of sterile distilled water to a unit of plasma. This gives a concentration three to four times greater than normal. Filtration is important before giving

**PROGNOSIS**

**TABLE 1**  
**Mortality Among Patients With Laryngo-Tracheo-Bronchitis**

| Author          | Cases        | Gross Mortality Per Cent | Tracheotomy | Deaths | Mortality Per Cent With Tracheotomy | Year         |
|-----------------|--------------|--------------------------|-------------|--------|-------------------------------------|--------------|
| Gittens .....   | 32           | 39                       | 20          | 12     | 80                                  | 1936         |
| Smith .....     | 43           | 9.3                      | 12          | 4      | 33                                  | 1936         |
| Baum .....      | 24           | 41                       | 17          | 9      | 53                                  | 1928         |
| Richards .....  | 28           | 40                       | 23          | 12     | 50                                  | 1937         |
| Felts .....     | 19           | 21                       | 17          | 4      | 23                                  | 1940         |
| Orton .....     | 62           | 28                       | 20          | 7      | 35                                  | 1940         |
| Galloway .....  | 10           | 20                       | 10          | 2      | 20                                  | 1939         |
| Davison .....   | 17           | 11.7                     | 9           | 1      | 11.1                                | 1940         |
| Brenneman ..... | 45           | 42.2                     | 24          | 10     | 41.7                                | 1938         |
| Howard .....    | (Total) 44   | 6.3                      | 16          | 4      | 25                                  | 1940 to 1943 |
|                 | (Serious) 20 | 35%                      | 16          | 4      | 25                                  |              |

Adopted from Orton.

is atelectatic. In later stages the semi-solid plugs or casts of the bronchi may be seen.

**TREATMENT**

Laryngo-tracheo-bronchitis may be treated either by medical therapy or by surgery, or both, according to the severity of the disease, but in any case the patient should be hospitalized.

and it is best to cut down on the vein in arm or ankle, so that subsequent injections may be given easily.

A preliminary venesection with removal of blood about three to four times the amount of plasma to be given, is advised because after the concentrated plasma is injected, the blood volume



TABLE 2

Mild Laryngo-Tracheo-Bronchitis Cases, 1940-1943—Total 20

| Name       | Age     | Retraction | Cyanosis | Croup Tent     | Sulfa Drug           | Hosp. Days                  |
|------------|---------|------------|----------|----------------|----------------------|-----------------------------|
| Best       | 34 mos. | Marked     | None     | Relief         | Thiaz.               | 6                           |
| Campbell   | 2 mos.  | None       | "        | Used           | Diaz.                | 15                          |
| Riley      | 22 mos. | "          | "        | "              | "                    | 8                           |
| Ault       | 12 mos. | "          | "        | "              | Meraz.               | 10                          |
| Thompson   | 30 mos. | "          | "        | "              | Thiaz.               | 3                           |
| Steen      | 24 mos. | "          | "        | "              | Thiaz.               | 4                           |
| Stigler    | 13 mos. | "          | "        | "              | Diaz.                | 4                           |
| Ottlinger  | 19 mos. | "          | "        | "              | Diaz.                | 8                           |
| Breen      | 4 yrs.  | "          | "        | "              | Diaz.                | 6                           |
| Nichols    | 18 mos. | Moderate   | "        | "              | Thiaz.               | 18                          |
| Hamiso     | 8 mos.  | Moderate   | Mild     | "              | Diaz.                | 6                           |
| Baynum     | 12 mos. | Moderate   | None     | "              | Diaz.                | 10                          |
| Phelps     | 3½ yrs. | None       | Slight   | "              | Thiaz.               | 16                          |
| Rush       | 8 mos.  | Marked     | Slight   | "              | Amide                | 7                           |
| Dolid      | 2 yrs.  | Marked     | None     | "              | Pyrad.               | 4                           |
| Thomas, B. | 4 yrs.  | Slight     | "        | H. Oxygen Tent | Pyrad.               | Bronchoscopy and Aspiration |
| Williams   | 5 yrs.  | "          | "        | Croup Tent     | Amide                | 7                           |
| Hill       | 12 yrs. | "          | "        | " "            | Pyrad.               | 4                           |
| Wehr       | 5 mos.  | Marked     | "        | " "            | Antitoxin<br>No. Dip |                             |

TABLE 3

(Serious) Laryngo-Tracheo-Bronchitis, 1940-1943; Total 20; Deaths 7; 35 Per Cent

| Name      | Sex | Age     | Retractions | Organisms                   | Sulfa Drug                      | Tracheotomy (16 Cases)        | Removal of Tube Days | Results                     |
|-----------|-----|---------|-------------|-----------------------------|---------------------------------|-------------------------------|----------------------|-----------------------------|
| Bentley   | M   | 6 mos.  | Severe      | H. Staph. Aureus            | Thiaz.                          | yes                           | 13                   | Improved                    |
| Ruehlman  | F   | 6 mos.  | Extremis    | No Culture                  | -----                           | -----                         |                      | Autopsy<br>Edema of Glottis |
| Wilson    | F   | 2½ yrs. | Marked      | Staph. Albus                | Pyrad.                          | yes                           | 13                   | Recovery                    |
| Sheridan  | M   | 18 mos. | Marked      | H. Staph. Aureus            | Thiaz.                          | yes                           | 14                   | Recovery                    |
| Wheatley  | F   | 10 mos. | Marked      | " " "                       | -----                           | yes                           | 10                   | Recovery                    |
| Beckett   | M   | 10 mos. | Marked      | " " "                       | Thiaz.                          | yes                           | 16                   | Recovery                    |
| M. Smith  | M   | 14 mos. | Severe      | " " "                       | Diaz.                           | yes                           |                      |                             |
|           |     |         |             |                             |                                 | 27 Broncho-                   | Not removed          |                             |
|           |     |         |             |                             |                                 | scopies                       |                      | Improved                    |
| Steuchli  | M   | 4 mos.  | Severe      | " " "                       | Diaz.                           | yes                           |                      |                             |
|           |     |         |             |                             |                                 | 4 Broncho-                    | 13                   | Recovery                    |
|           |     |         |             |                             |                                 | scopies                       |                      |                             |
| J. Bland  | M   | 4 mos.  | Severe      | " " "                       | Thiaz.                          | yes                           | 23                   | Recovery                    |
| P. U.     | M   | 3 yrs.  | Marked      | No Culture                  | Thiaz.                          | yes                           | 15                   | Recovery                    |
| T. Rach   | M   | 6 yrs.  | Marked      | " " "                       | Diaz.                           | yes                           |                      |                             |
|           |     |         |             |                             |                                 | 16 Broncho-                   | 19                   | Recovery                    |
|           |     |         |             |                             |                                 | scopies                       |                      |                             |
| L. Brooks | F   | 2 yrs.  | Slight      | Hemo. Staph. Aureus         | Thiaz.<br>Adrenalin<br>Coramine | no<br>2 Broncho-              | 8                    | Recovery                    |
|           |     |         |             |                             |                                 | scopies                       |                      |                             |
| C. Gray   | F   | 10 mos. | Extremis    | H. Strept.                  | -----                           | -----                         |                      | Autopsy<br>Edema of Glottis |
| Cummins   | M   | 9 yrs.  | Marked      | H. Strept.<br>Green Strept. | Thiaz.                          | yes                           | 5                    | Recovery                    |
| Nations   | M   | 1 yr.   | Marked      | H. Staph. Aureus            | Diaz.                           | yes                           | 20                   | Recovery                    |
| J. H.     | M   | 4 yrs.  | Marked      | " " "                       | Thiaz.                          | yes                           |                      | Autopsy<br>Pneumonia        |
| Seaman    | M   | 16 mos. | Marked      | " " "                       | Thiaz.                          | yes                           |                      |                             |
|           |     |         |             |                             |                                 | 3 Broncho-                    |                      | Died                        |
|           |     |         |             |                             |                                 | scopies                       |                      |                             |
| Kraps     | F   | 17 mos. | Marked      | Pneumo. Type 19             | Diaz.                           | yes                           |                      |                             |
|           |     |         |             |                             |                                 | 3 Broncho-                    |                      | Died                        |
|           |     |         |             |                             |                                 | scopies                       |                      |                             |
| Kayser    | F   | 15 mos. | Marked      | No Culture                  | Diaz.                           | H. Plasma<br>yes              |                      |                             |
| Oliver    | M   | 4 mos.  | Severe      | No Culture                  | Diaz.                           | H. Plasma<br>yes<br>H. Plasma |                      | Died<br><br>Died            |

is increased by that amount. This venesection is not always necessary and has not been done in all our cases but, theoretically, it is probably correct in reducing congestion and preventing overloading of the circulation. From 25 to 40 c.c. of concentrated plasma should be given at 8 to 12-hour intervals according to the severity of the obstruction.

Drs. R. Hilsinger and T. Edwards at the Cincinnati General Hospital have given 50 per cent glucose in saline while preparing the plasma, with equally excellent temporary results. It is also wise to keep the patient in a humidified oxygen tent while preparing the plasma, especially if the patient is having marked dyspnea and retractions.

If the retractions become worse then laryngeal and tracheal aspiration and inspection through a laryngoscope is indicated. If this does not

not believe they are of any value except in eliminating some secondary invaders. I am anxious to try penicillin when it is available to civilian use, but do not expect any remarkable result from chemo-therapy.

The use of morphine and atropine are contraindicated due to the respiratory paralysis inhibiting the cough reflex with the use of opiates and the secretory inhibition with atropine. Diphtheria anti-toxin should be given in large doses and early if the larynx is at all suspicious looking on direct laryngoscopy.

The humidifier\* adapted for the oxygen tent as suggested by Davison and Richards was used at the Cincinnati Children's Hospital for all my cases so indicated. When other methods before mentioned failed to relieve the laryngeal obstruction then a tracheotomy was performed in 16 of the 20 serious cases reported.

TABLE 4  
Cases Treated With Hypertonic Plasma, 1940-1943; Total 7; Deaths 3

| Name      | Sex | Age     | Retractions | Organisms        | Croup Tent   | Sulfa Drug | Hypertonic Plasma | Hosp. Days |
|-----------|-----|---------|-------------|------------------|--------------|------------|-------------------|------------|
| Carpenter | M   | 4 mos.  | Marked      | H. Staph. Aureus | Used         | Diaz.      | (2) 20cc          | 31         |
| Shelton   | M   | 18 mos. | "           | Strept. Viridans | "            | Diaz.      | (3) 40cc          | 12         |
| Linn      | M   | 2½ yrs. | "           | Green Strept.    | "            | Thiaz.     | (1) 25cc          | 4          |
| D. G.     | F   | 14 mos. | "           | H. Staph.        | "            | Diaz.      | (3) 20cc          | 8          |
| S. K.     | M   | 17 mos. | "           | Pneumo. Type 19  | Bronchoscopy | Diaz.      | (2) 40cc          | 12         |
| Kayser    | F   | 15 mos. | "           | No Culture       | Tracheotomy  | Diaz.      | (4) 20cc          | 4          |
| Oliver    | M   | 4 mos.  | "           | " "              | Tracheotomy  | Diaz.      | (1) 20cc          | 1          |

relieve the symptoms then either an intubation tube or bronchoscope should be inserted through the subglottic obstruction and the decision made as to whether or not a tracheotomy should be done.

Our results so far with hypertonic plasma on private cases of laryngeal-tracheo-bronchitis has been limited to seven cases, with marked improvement in four and progressive changes, and death in three. Other uses in ear, nose and throat for hypertonic plasma are:

1. Post-bronchoscopic traumatic obstructive edema.
2. Vegetal foreign body reactions.
3. Supra-glottic or subglottic laryngitis with edema and obstruction.
4. Angioneurotic edema.
5. Bronchial asthma or pulmonary edema.

The questions frequently raised in connection with hypertonic plasma, is the benefit obtained from the osmosis dehydration theory or from enough anti-bodies in the plasma which help neutralize the toxin in the tissues? Our experience with anti-virus whole blood has been so spectacular that we are inclined to lean toward the latter theory.

The use of the sulfa drugs has been very disappointing and although used in every case I do

The easiest way to open the trachea is to first pass a small bronchoscope through the larynx and then incise in the midline through the skin and superficial fascia. Blunt dissection with either hemostats or with blunt hook retractors (as designed by Dr. Jackson, Dept. Pharmacology, University of Cincinnati) will expose the trachea. An incision is made through the second, third and fourth tracheal cartilages with introduction of tracheal tube (appropriate size) into the trachea by spreading the incision with nasal speculum or Trousseau dilator as your assistant withdraws the bronchoscope.

The patient is then returned to either humidified room or oxygen tent attempting to keep humidity at 90-95 per cent and is frequently aspirated. Adequate nursing service around the clock is a necessity. Bronchoscopic equipment and service at the bedside is also important.

#### SUMMARY

1. Definition, symptoms, etiology, pathology, prognosis, and treatment of laryngo-tracheo-bronchitis.
2. Conservative treatment using hypertonic plasma.
3. Tracheotomy when absolutely necessary followed by careful nursing and medical service.

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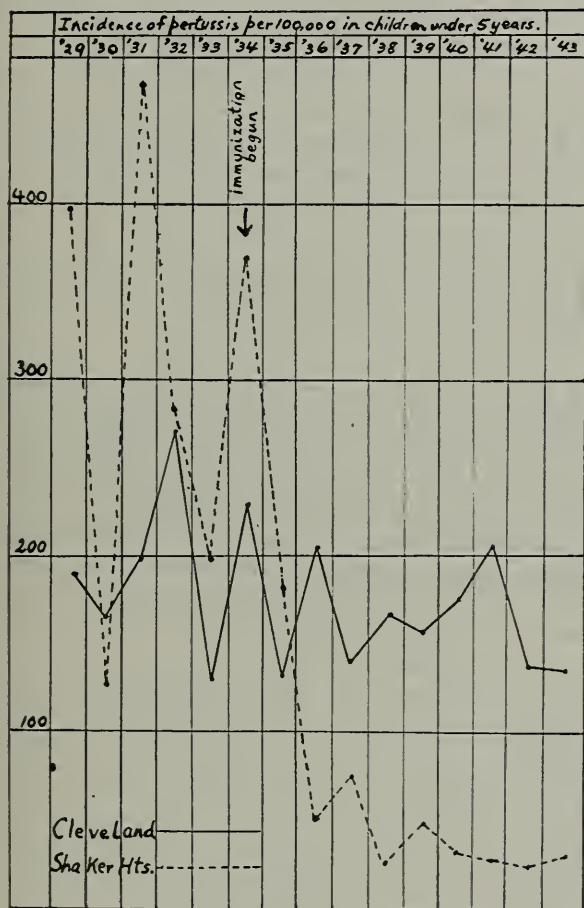
# Efficacy of Whooping Cough Vaccine

JUSTIN A. GARVIN, M.D.

IN a previous paper data were presented comparing the incidence of whooping cough in children under five years of age in two adjacent cities. One of the cities, Cleveland, with a population of about 900,000 had a small percentage (est. 10 per cent) of its preschool children immunized against whooping cough by vaccine, while the other city, Shaker Heights, an adjacent residential suburb of 25,000 people had a high

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percentage (est. 75 per cent) of its preschool population immunized against whooping cough, mostly according to the method recommended by Sauer.<sup>2</sup>

sequent period of six years (1934-1939). The conclusion arrived at was that the use of whooping cough vaccine (Sauer's) as a prophylactic seemed justified.

During the past four years (1940-1943) data similar to that obtained for the preceding 11 years has been obtained and incorporated in a table and graph for the entire 15-year period.

The prophylactic immunization of Shaker Heights infants against whooping cough has continued at a high rate, being done now as routinely as immunization against diphtheria and small pox. In metropolitan Cleveland there has been a moderate increase in the number immunized against whooping cough due to the efforts of private physicians as its child health centers and hospital outpatient departments generally do not immunize against whooping cough.

It is evident, from the graph, that in the past four years the incidence of preschool whooping cough in Shaker Heights has continued at a stable low level while its incidence in Cleveland averages slightly lower than before.

The records of the health department of suburban Shaker Heights show two other items of interest concerning whooping cough.

1. None of the cases (6) of preschool whooping cough reported in 1943 had received prophylactic immunization against the disease.

2. During the past three years (1941-1943) a total of 10 cases of whooping cough have been reported in children over five years of age. Added to the 17 cases in this period reported in children under five years of age, we get a total of

TABLE  
Incidence (per 100,000 population) of pertussis in children under 3 years.

|                | 1929 | 1930 | 1931 | 1932 | 1933 | 1934 | 1935 | 1936 | 1937 | 1938 | 1939 | 1940 | 1941 | 1942 | 1943 |
|----------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Shaker Heights | 397  | 127  | 471  | 287  | 198  | 365  | 182  | 54   | 74   | 21   | 45   | 30   | 26   | 21   | 26   |
| Cleveland      | 189  | 164  | 198  | 270  | 180  | 229  | 131  | 206  | 140  | 167  | 157  | 175  | 207  | 137  | 135  |

Tables and a graph were presented showing the incidence of preschool pertussis in each of these cities for a period of five years (1929-1933) before immunization was started and for a sub-

27 cases of whooping cough in children of all ages in three years' time.

## COMMENT

To justify continuation of an immunization procedure ample evidence of its effectiveness should

be presented. It is believed that such evidence is contained in this paper which shows that a residential suburb of about 25,000 people has through immunization reduced its cases of pre-school whooping cough to a yearly average of six during the past four years and that during the calendar year 1943 none of the six reported cases of whooping cough occurred in children who had received prophylactic whooping cough vaccine.

Apart from data presented in this paper, I find confirmatory evidence of the efficacy of vaccine in preventing whooping cough in not having encountered during the past eight years a single case of whooping cough in my private practice among children whom I had immunized against the disease, according to Sauer's recommendations, subsequent to the year 1935.

#### CONCLUSION

The prophylactic immunization of infants and young children against whooping cough by private physicians and pediatric clinics in health centers and hospitals should be as standard practice as immunization against diphtheria and small pox.

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### Sayings of a Psychiatrist

Joseph L. Fetterman, M.D.

Action absorbs anxiety.

\* \* \*

They who love dogs usually care for the underdog.

\* \* \*

Like a light extinguished by a time switch, so the mood of a depressed patient becomes darkened, turned off by a time clock wound by the fingers of destiny.

\* \* \*

The veteran is skeptical of words of gratitude when they are followed by acts of greed.

\* \* \*

Morale is like a mantle of invincibility, the wearer of which feels stronger, fears less, fights harder. What is the fabric of which this mantle is woven? Its foundation is faith, faith in the cause for which we fight. In its texture are interwoven confidence in our leaders, security in our weapons, a trust in the equality of our sacrifices. The fabric is waterproofed by a will to victory that readily accepts hardships. Like an unseen mantle in mythology, morale is the true secret weapon.

\* \* \*

Occupational therapy means constructively occupied time.

\* \* \*

The important product in occupational therapy is building the confidence of the patient.

### KEEPING UP WITH MEDICINE

IT is almost a certainty that a niche located on the greater curvature of the stomach is malignant. At least, it should be so considered until proven otherwise.

\* \* \*

THE psychogenic factors in disease may well have their treatment summed up in three words—Relaxation, Reassurance, and Readjustment.

\* \* \*

THERE are certain hazards which the diabetic is more likely to encounter, i.e., coronary occlusion, peripheral vascular disease, infections of the extremities and acute pyelonephritis.

\* \* \*

ALTHOUGH the pathologic basis of asthma was once supposed to be the spasm, it is a curious fact that spasm has never been demonstrated in any case studied by bronchoscopy.

\* \* \*

LONGEVITY without health is both an individual and a social tragedy.

\* \* \*

MANY cases of Loeffler's syndrome are appearing in the literature, although there were only 105 all told in 1940. The symptoms as a rule are mild. In fact in 25 per cent of cases the condition is discovered accidentally. There is rarely any fever. A cough with frothy, mucoid sputum may be present. There are a few moist rales. The sedimentation rate of the red blood cells is usually increased.

X-ray examination reveals a more extensive lung infiltration than was suspected from the clinical examination. The shadows appear and disappear rapidly only to reappear in another part of the lungs. The eosinophilia ranges from 15 to 60 per cent. It most often occurs in July and August and males are most frequently affected. It is an allergic response to various allergens and will be found more often as the profession becomes allergy conscious.

\* \* \*

PAROXYSMAL nocturnal dyspnea is one of the first serious signs of congestive heart failure. This is the result of left heart failure. Physiologically, it is due to poor oxygenation of the blood during sleep with an increased flow into the right heart, consequent pulmonary engorgement and acidosis of the respiratory center.

\* \* \*

THE Army reports that Sulfadiazine cuts the death rate from meningitis by 90 per cent from 93.2 per cent in the war between the states and 39.2 per cent in the last war to the present rate of less than 3 per cent.—J. F.



# Recto-Perineal Fistula: An Unusual Obstetric Complication\*

WYNNE M. SILBERNAGEL, M.D., OLAN P. BURT, M.D., and  
JAMES B. PATTERSON, M.D.

**E**PISIOTOMY or perineotomy is a prophylactic obstetric operation intended to prevent injuries to the bladder, urethra, vagina, rectum, anus and peri-anal structures. As is true of any operative procedure complications may arise. The more common complications are extension of the incision and infection of the incision preventing primary union. We wish to call to attention a previously unreported complication, viz., the conversion of a blind internal rectal sinus into a complete rectal fistula in the performance of medio-lateral perineotomy.

A review of the literature reveals reports of only six cases of rectal fistulae complicating perineotomy.<sup>1</sup> The etiologic factor in these cases was the passage of a deep suture through the rectal mucosa during the repair of the perineotomy. The treatment of these cases consisted of opening the fistulae over a probe.

We have recently had two patients who developed recto-perineal fistulae following perineotomy. The etiologic factor in these cases was not the perforation of the anal or rectal mucosa by suture material as rectal examination immediately following the reconstruction of the perineum did not reveal the presence of suture material in the anorectal canal.

## REPORT OF PATIENTS

Since the two patients who developed recto-perineal fistulae were similar in development and treatment, they will be reported together. One patient was a primi-gravida and the other had one child who had been delivered by cesarean section, the indications for the operation being "over due". The first patient had a breech presentation and was delivered by single footling extraction. The second patient had a cephalic presentation and was delivered by low forceps. The duration of labor in each patient was seven hours and in both patients right medio-lateral perineotomy was employed. In both patients repair of the perineotomy was done by uniting the severed muscular and fascial planes with interrupted sutures of No. 1 chromic catgut.

In each patient the post-partum course was uneventful, with the exception of considerable perineal pain, for eight days. On the eighth day the skin edges of the perineotomy repair separated and fecal material and gas was passed

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through the incision. In both cases the fistulae were ventral to a transverse line drawn through the anus which suggested the possibility of a high blind internal rectal sinus as we were certain that no suture material had been passed through the ano-rectal mucosa.

## DIAGNOSIS

Competent proctological consultation was obtained for both patients and in each patient internal openings of fistulae were found on the anterior rectal wall about one inch above the internal sphincter.

## TREATMENT

Treatment in each case consisted of high residue diet, avoidance of laxatives, rectal and perineal irrigations three times daily with one dram sodium sulfathiazole in one pint of water. Sulfathiazole powder was liberally applied to the perineotomy incision several times daily. In the first patient the fistula closed in ten days and in the second patient in six weeks.

## DISCUSSION

A blind internal sinus usually produces some type of rectal discomfort but in these patients there were no symptoms referable to the rectum or anus before delivery. Theoretically a fistula is the end result of an abscess in the ano-rectal area. The only tissues in the ano-rectal area resistant to infection are the fascial layers. As a result, the original ano-rectal abscess cavity ramifies in various directions in the fatty-cellular tissue and when it is evacuated, contraction

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Submitted September, 1944.

of the walls of the abscess cavity results in a tract that is deviating and tortuous.<sup>2</sup>

In performing medio-lateral perineotomy, the cutting angle of the scissors is placed at the fourchette and the tips of the scissors directed toward the corresponding ischial tuberosity. The tissues thus severed are the skin, superficial perineal fascia, superficial transverse perineal muscle, bulbocavernosus, deep perineal fascia, a portion of the levator ani and fatty tissue in the region of the ischio-rectal fossa.

An incomplete internal rectal sinus may inadvertently be opened in the performance of perineotomy. If this incision is properly repaired the muscular and fascial layers will be gently approximated and will serve as a temporary barrier to the further extension of the blind sinus. In a few days, however, the blind sinus tract will be converted into a complete recto-perineal fistula as the continuity of the fascial barriers was destroyed by the perineotomy. Even though the anatomic planes were reestablished by the perineal reconstruction small areas permitting the extension of infection were established between the sutures and by the passage of the sutures.

An explanation for the rarity of this complication is that most rectal sinuses and fistulae have their internal openings in the posterior commissure of the anal canal and the sinus does not extend far laterally from the anal canal. The majority of rectal fistulae and sinuses with anterior internal rectal openings occur in women.

#### SUMMARY AND CONCLUSIONS

1. A report is given of two patients presenting a rare complication of perineotomy.
2. A silent blind internal rectal sinus may inadvertently be converted into a complete rectal fistula in the performance of perineotomy.
3. The treatment of recto-perineal fistula in two patients was non-surgical.
4. If an anterior rectal sinus is discovered antepartum, this complication could probably be avoided by performing median perineotomy.

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Morbidity from tuberculosis in adolescence and early adult life is more frequently the result of household exposure after childhood than before, indicating that in early adult life infection from the environment is of greater importance than the breakdown of lesions acquired in childhood.—Harold L. Israel, M.D., and Horace DeLein, M.D., *Amer. Jour. of Pub. Health*, Oct., 1942.

## Tuberculosis In Elderly People

The importance of tuberculosis in elderly people, especially pulmonary tuberculosis, has been generally underestimated. One reason for this is that few of us have any conception of the number of older people among us. There are in the United States nearly four thousand persons over 100 years old; over 87 thousand who are past 90; more than one million who are over 80; more than five million over 70; and 13.5 million over 60. These, with 13 million in their fifties, makes a total of over 26.5 million persons over 50, more than 20 per cent of the whole population.

The U. S. Census figures for 1870 showed only about 11 per cent of the population over 50 at that time. A reduction in mortality from infectious disease, increased application of sanitary science, better housing and nutrition are all contributing to the longer life of the present day. How permanent the present large percentage of older people in the population will be, we can not tell. Continued wars followed by widespread epidemics, may again reduce life expectancy to that of the middle ages.

Now, however, when about one-fifth of our population is elderly, it is important that we know how much of it harbors tuberculosis, and how much of a menace to the community this represents. Is tuberculosis in the later decades of life increasing?

Figures from the U. S. Census Bureau show that the mortality rates from tuberculosis in the United States in 1940 were much higher in the later decades of life than among young people. The highest rate in 1940 at any age period, that of males between 55 and 65, was 110 per 100,000. In 1900 the highest rate for males, 362 per 100,000, was in the age period, 35 to 39.

The death rate from tuberculosis is still relatively high in persons over 50, and since this group forms about 20 per cent of the population, there are many elderly tuberculous persons in the country. Using the very conservative factor of five active cases for every death, the active cases, many of which are spreading infection, may be estimated as at least 100,000. Not all of these cases are in sanatoria.—A. T. Laird, M.D., *The Journal-Lancet*, June, 1944.

About 150,000 tuberculosis individuals have been prevented from entering the armed forces by the use of a chest X-ray in the preinduction examination—Esmond R. Long, Colonel, MC, U. S. Army.

The healthy know not their health, but only the sick.—Thomas Carlyle.



# The Blood Sedimentation Rate: Factors Influencing Its Determination and Interpretation

ROBERT G. LEHMAN, M.D.

THE determination of the blood sedimentation rate is one of the simplest and most inexpensive of laboratory procedures and has attained widespread use because of its applicability to all phases of medicine. There is, unfortunately, no standard method for performing the reaction, and the variety of technics and methods for expressing results continues to cause confusion.<sup>2,7</sup> Since the rate of sedimentation of erythrocytes is "a measure of the presence and intensity of morbid processes within the body,"<sup>15</sup> it is the purpose of this discussion to review the salient features of the sedimentation reaction and to appraise the factors influencing its scope of usefulness.

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There are 5 commonly used methods, a table of which is reproduced from *The Journal of the American Medical Association*.<sup>2</sup> The variations in these methods effect specific normal and abnormal sedimentation values for each of the respective

COMPARISON OF FIVE COMMONLY USED SEDIMENTATION METHODS

|                        | Rourke-Ernstene                                                     | Wintrobe-Landsberg            | Westergren                  | Linzenmeier           | Cutler                                               |
|------------------------|---------------------------------------------------------------------|-------------------------------|-----------------------------|-----------------------|------------------------------------------------------|
| SEDIMENTATION          |                                                                     |                               |                             |                       |                                                      |
| Tube Length            | 120 mm.                                                             | 120 mm.                       | 300 mm.                     | 65 mm.                | 70 mm.                                               |
| Internal Diameter      | 4 mm.                                                               | 2.5 mm.                       | 2.5 mm.                     | 5 mm.                 | 5 mm.                                                |
| Height of Blood Column | 100 mm.                                                             | 100 mm.                       | 200 mm.                     | 50 mm.                | 50 mm.                                               |
| ANTICOAGULANT          | Heparin & Dry Oxalate; K <sub>2</sub> C <sub>2</sub> O <sub>4</sub> | Dry oxalate                   | 3.8% sod. citrate           | 5% sod. citrate       | 3% sod. citrate                                      |
| METHOD OF TIMING       | Slope of period of constant fall                                    | Distance in 1 hr.             | Dist. in 1 hr.              | Time to settle 18 mm. | Graph of curve & dist. in 1 hr.                      |
| SED. RATE UNITS        | mm. per min.                                                        | mm.                           | mm.                         | min.                  | slope of curve & mm.                                 |
| NORMAL RANGE           | 0.05-0.4 mm./min.                                                   | 0.9 mm., men; 0-15 mm., women | 1-3 mm., men 4-7 mm., women | 200-600 min.          | Horizontal line; 2-8 mm. for men; 2-10 mm. for women |

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All technics of performing the sedimentation test are based on the same principle: Blood is essentially a suspension of erythrocytes in plasma; the stability of this suspension is measured by mixing blood with an anticoagulant and allowing the mixture to stand in a narrow tube in the vertical position. All methods are modifications of two principal methods: The velocity of settling may be expressed as the number of millimeters the column of red blood cells settles in a unit of time (usually 60 minutes), or as the number of minutes required for the upper level of sedimenting corpuscles to fall a specified distance. (Linzenmeier method<sup>2,3,15</sup>). The former method is simpler and more widely used because it is easier to fill the tube and pay no more attention to it until a specified time has elapsed.<sup>15</sup>

The opinions stated and assertions made in this article are those of the writer and are not to be construed as reflecting those of the Navy Department or the Naval Service at large. Submitted April, 1944.

methods. These variations are, in effect, the physico-chemical factors which influence the results of the reaction.

## PHYSICO-CHEMICAL FACTORS INFLUENCING THE SEDIMENTATION RATE

1. Length of tube: It is apparent that the tube must be of uniform length and that the length will be a factor in the velocity of settling. The tube lengths in the five commonly used methods vary from 65 to 300 mm.

2. Internal diameter of tube: The internal bore of the tube in the five macromethods varies from 2.5 to 4 mm. Wintrobe and Landsberg<sup>5</sup> as well as Ham<sup>11</sup> have pointed out that the settling of erythrocytes in tubes whose internal diameter is 2 mm. or less, may be slow and uneven. The microsedimentation tests represent a modification of the methods described by Landau;<sup>22</sup> although the method is reliable and simple,

it shares the inadequacy of other types of sedimentation apparatus in which a capillary pipet is employed, inasmuch as the column of citrated blood settles within a capillary tube whose inside bore is 1 mm. The accuracy of the microsedimentation method is less than that achieved with macromethods. The ideal micromethod is one which utilizes capillary blood but which employs a sedimentation tube with the basic specifications of a standard venipuncture method, as outlined by Cutler<sup>23</sup> and Smith.<sup>24</sup>

3. Volume of blood: As the volume of blood is decreased, the rate of sedimentation is increased. Thus, a more rapid fall occurs in anemia; the sedimentation may not occur at all in polycythemia.<sup>15</sup> Variations in erythrocyte concentrations produce less alteration of the sedimentation rate in the Westergren procedure than for technics employing anticoagulants which do not dilute the blood significantly, such as heparin, potassium oxalate and the potassium oxalate-ammonium oxalate mixture. Anemia does produce a moderate increase in the sedimentation rate with the Westergren method, but correction for anemia is unsatisfactory and is seldom employed.<sup>11</sup> No set figures can be given for the effect of anemia, since the sedimentation rate is influenced both by the volume of erythrocytes in suspension and by the size of the red blood cell, i.e., whether macrocytic or microcytic.<sup>11</sup> In blood samples with decreased erythrocyte volume, the sedimentation values are increased.<sup>2</sup>

4. Anticoagulant: Sodium citrate solutions in the concentrations used with the Linzenmeier and Cutler technics (3 to 5 per cent), retard the sedimentation rate considerably. Changing the proportion of the citrate solution used for the Westergren technic or substituting potassium oxalate as the anticoagulant do not improve the original method of Westergren, but add further confusion by changing the values for normal subjects and increase the effect of anemia, which is minimal in the original Westergren method. Change in the anticoagulant to a small volume of potassium oxalate alters the characteristics of the settling velocity, increases the rate for normal subjects and increases the effect of anemia.<sup>2</sup> It is true, however, that the ammonium oxalate-potassium oxalate mixture used in the Rourke-Ernstene and Wintrobe-Landsberg methods, has no effect on sedimentation rate or erythrocyte cell volume. Potassium oxalate in 20 per cent solution may be used alone as the anticoagulant without producing significant alteration of the rate. An excess of anticoagulant will delay the rate.<sup>15</sup>

5. Time of withdrawal of blood: Blood must be used within 4 hours of the time of its withdrawal or the rate of sedimentation may be less than that in freshly drawn blood.<sup>15</sup>

6. Temperature: Excessive cold slows the sedi-

mentation rate and heat accelerates it; the ideal temperature for carrying out the procedure is from 22 to 27 C.<sup>15</sup>

7. Position of the tube: The tube must be in the vertical position; as little as 3 degrees from the vertical will cause a marked acceleration of the rate.<sup>15</sup>

A quantitative comparison of the five commonly used sedimentation methods has been made by Ham and Curtiss<sup>11</sup> and by Hambleton and Christianson.<sup>20</sup> The Westergren method is probably more used than any other method and is to be recommended because a single reading taken at the end of one hour, uncorrected for anemia, has a high degree of correlation with the concentration of plasma fibrinogen.<sup>2</sup> However, use of the Wintrobe hematocrit with the mixture of ammonium and potassium oxalates as the anticoagulant, would probably be as simple and as accurate as the Westergren method and would have the additional advantage of the simultaneous hematocrit calculations and the determination of the icterus index on the same sample.<sup>15</sup>

#### PHYSIOLOGIC AND PATHOLOGIC FACTORS INFLUENCING THE RATE

The cause of erythrocyte sedimentation is unknown.<sup>15</sup> The chief factor is in the plasma, for sedimentation in plasma is more rapid than sedimentation in serum. Variations in the suspension stability depend on the differences in the degree of aggregation of red blood cells, with resulting formation of larger or smaller particles. In bloods which settle rapidly, larger aggregates are formed.<sup>15</sup>

Clinically, acceleration of the sedimentation rate is associated with those processes which are accompanied by inflammation or necrosis or by an increase in the fibrinogen content of the plasma.<sup>8</sup> An abnormal elevation in the concentration of plasma fibrinogen and in the sedimentation rate is one of the most frequent responses of the body to a variety of noxious stimuli, such as tissue inflammation or destruction, whether traumatic, chemical, bacterial or neoplastic.<sup>9</sup>

There is a close correlation between the quantity of plasma fibrinogen and the rate of sedimentation, and there is some correlation between the amount of plasma globulin and the sedimentation rate.<sup>15</sup> The sedimentation rate serves as a rough index of plasma fibrinogen concentration, and an increased rate is usually associated with an abnormal elevation in the plasma globulin concentration, especially fibrinogen.<sup>2</sup> But as Wintrobe<sup>15</sup> points out: "... it is not correct to assume, as many writers have done, that the increased rate is therefore due to increases in plasma fibrinogen or globulin. The real causative factor has not been demonstrated".

Physiologically, fibrinogen production is increased in normal pregnancy, an observation first



made by Fahraeus.<sup>10</sup> Occasionally, the rate is increased above normal associated with an increase in the concentration of serum globulin in such diseases as hepatic cirrhosis, multiple myeloma, lymphogranuloma inguinale, and chronic infection.<sup>9</sup> An abnormally slow sedimentation rate is an unsatisfactory measure of plasma proteins and can be interpreted only as compatible with normal.<sup>9,11</sup> The sedimentation rate fails as an index of plasma fibrinogen when there are abnormally elevated levels of serum globulin or of lipids and when there is advanced change in the size of the red blood cells.<sup>2</sup> Ham and Curtis<sup>11</sup> have discussed the relation of plasma proteins, especially fibrinogen and serum globulins, to the sedimentation rate.

It has been reported that the rate is prolonged in allergic states, certain virus infections, certain cases of brucellosis, pertussis, and liver disease.<sup>2</sup> This indicates that the concentrations of fibrinogen and globulins are not elevated in these diseases. A normal or so-called prolonged rate, therefore, is indirect evidence that the plasma and serum proteins are not elevated above normal concentrations, but a normal rate is not a reliable index for abnormally decreased concentrations of these proteins.<sup>11</sup>

Slight variations in the values of the sedimentation rate occur in health and distinct differences are found in the different sexes. Wintrobe<sup>15</sup> believes that the differences between sexes is largely accounted for by the quantitative difference in the erythrocyte counts of men and women. The increased rate in pregnancy gradually increases from the tenth to the twelfth week and the rate does not return to normal until the third to fourth week of the puerperium.<sup>15</sup>

#### CLINICAL APPLICATION

It is apparent from the foregoing that the erythrocyte sedimentation rate is a nonspecific reaction which may be compared with temperature, pulse rate and leucocyte count in that it offers information of a general character. In this respect the sedimentation rate is less specific than the white blood cell count because of the particular inference which may be made from the differential leucocyte examination.<sup>15</sup> In many disorders and even certain stages of febrile disease, there may be no fever or tachycardia and the white blood cell count and differential examination may be normal; yet in such instances the erythrocyte sedimentation rate may be increased and thus serve as a complementary clinical tool.<sup>15</sup>

In 1932 Cutler<sup>12</sup> reported the results of the determination of the sedimentation rate in 5,000 patients over a six-year period. In his summary he states: "As a diagnostic aid, an increased rate indicates disease; as a prognostic index, and similarly as a guide in treatment, the rate

of sedimentation has been shown to be a more accurate and reliable reflection of the real condition of the patient than our usually accepted procedure".

Acute generalized infections increase the rate in proportion to the severity of the infection. An abnormal rate subsides more slowly than the temperature and serves as a guide to the condition of the patient after fever and tachycardia have disappeared. The rate increases in complications and often indicates the onset of a complication before its nature and site has been determined.<sup>15</sup> An acute suppurative process usually produces an elevation in the rate after the third or fourth day, especially if there are generalized manifestations from the abscess. A localized process may not increase the rate.<sup>9</sup>

In general, chronic inflammatory processes do not produce an accelerated sedimentation rate. So-called focal infections influence the rate in proportion to the underlying pathologic process, whereas chronic localized infections may have no influence. However, chronic inflammatory conditions characterized by exudative reaction (pelvic inflammatory conditions, tuberculosis, chronic bronchitis) may cause significant increase in the velocity of the sedimentation reaction.<sup>9</sup>

The rate of sedimentation is usually normal in simple catarrhal inflammation (acute catarrhal appendicitis, rhinitis, bronchitis).<sup>15</sup> Blaisdell and Smith<sup>8</sup> in 500 unselected patients found the rate consistently normal also in neuropsychiatric conditions, diabetes mellitus, benign tumors, sprains and lacerations. In this same study the rate was found usually accelerated in acute pyogenic infections, pneumonia, tuberculosis, malignant disease, fractures, during the last two trimesters of pregnancy, during the postpartum period and following abdominal surgery.

The sedimentation rate is accelerated in practically all phases of progressive febrile tuberculosis, and although it has no specific value diagnostically, the determination is useful particularly in helping to ascertain the activity of the pathologic lesion.<sup>16,25</sup> Variations in the rate "reflect the intensity of the morbid process more accurately than the pulse, temperature, weight, sputum, symptoms, or physical signs".<sup>15</sup> Its reliability in this respect must be accepted with certain qualifications, "since the rate may be entirely within normal limits during the initial phases of the early pulmonary lesion, in more advanced cases when the patient is kept quietly at rest in bed, and in old fibroid cases even though a pulmonary cavity may be present".<sup>16</sup>

However, Wintrobe<sup>15</sup> states that at the Trudeau Sanatorium it was found that in some instances an increased rate warned of relapses before new shadows were to be found on roentgenograms. A particular application of the sedi-

mentation rate in tuberculosis is its use in patients who are not under constant observation, as in those under therapy with artificial pneumothorax. The Cutler method<sup>14</sup> is especially applicable to evaluating the tuberculous lesion.

The sedimentation rate in general is a good index of activity in rheumatic fever. In acute stages the rate is usually 100-300 mm. by the Westergren technic. (Normal: 1-3 mm. for men, 4-7 mm. for women, in 60 minutes.)<sup>17</sup> With improvement in the pathologic process, the rate drops; in monocyclic cases rates of 30-60 mm. per hour are long maintained. Rates above 20 mm. are probably indicative of the need for continued rest. In patients with chorea the rate is often normal, but, "abnormal curves are generally better indicators of the rheumatic infection than is leucocytosis. Both considered together are better than either alone".<sup>17</sup>

The sedimentation rate is accelerated in acute infarction of the myocardium (coronary thrombosis) and in syphilitic aortitis, whereas the rate is ordinarily normal in hypertensive heart disease and angina pectoris.<sup>15,26</sup> In myocardial infarction the sedimentation test decides the duration of rest, as it does in rheumatic fever.

The rate of sedimentation is usually accelerated in inflammatory disease of the bones and joints, such as rheumatoid arthritis,<sup>21</sup> and in active cases of the latter the rate may be three to four times its normal value.<sup>18</sup> In gout, sedimentation rates may be normal in mild attacks, elevated in severe acute attacks and in chronic gouty arthritis.<sup>19</sup> However, Hench<sup>19</sup> states that in gout, sedimentation rates and values for blood uric acid content do not apparently reflect related factors. In degenerative joint disease (hypertrophic or osteo-arthritis) the sedimentation rate is usually normal.<sup>15</sup>

Recent investigations<sup>13</sup> on the sedimentation rate in mumps revealed normal values in uncomplicated mumps and mumps meningitis and markedly increased values in mumps orchitis.

In the appraisal of new growths the rate of sedimentation is determined by anatomic character, vascularity, tendency to break down, the degree of resorption of the tumor, the degree of reactive inflammation and the presence of metastases.<sup>15</sup> In gynecologic practice, the sedimentation rate is particularly useful in the diagnosis of acute inflammatory conditions within the pelvis.

As Wintrobe<sup>15</sup> has summarized, the most important function of the sedimentation reaction is its bringing to attention more or less occult diseases; in this respect the reaction is valuable as a routine procedure. It may be the sole evidence of the presence of disease and thus indicate the need of further study of the patient.

## SUMMARY

1. The blood sedimentation reaction is one of the simplest, most inexpensive and most diagnostically valuable of laboratory procedures.

2. It has widespread use and application in all phases of medicine.

3. Acceleration of the erythrocyte sedimentation rate is associated with those processes which are accompanied by inflammation or necrosis or by an increase in the fibrinogen content of the plasma.

4. The rate may be increased when there occurs an elevation of the concentration of serum globulin or plasma fibrinogen.

5. Correct interpretation of the sedimentation reaction demands a knowledge of the physico-chemical and physiologic-pathologic factors influencing the velocity of the reaction. Only with such knowledge is the clinician able to appraise the test to its fullest extent.

6. The sedimentation rate is a valuable non-specific index of disease and is useful diagnosis, prognosis and therapy.

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## Heart Disease

The pulse rate at rest is normal, or nearly so, and quite normal during sleep. But even on slight effort it increases to a much higher rate than is manifested in a normal individual even after extreme effort. In normal individuals the pulse rate returns to normal within two minutes or less after effort. In these patients the return to the previous level is much slower.—Newell Clark Gilbert, M.D., Chicago; Jr. Ind. State Med. Assn., Vol. 38, No. 2, Feb., 1945.



# The Use of Penicillin in Streptococcus Veridans Blood Stream Infection

KENT E. MARTIN, M.D., and RALPH F. SCHNEIDER, M.D.

IN reviewing the available literature we find that there have been very few cases of sub-acute bacterial endocarditis which have been successfully treated by either the sulfonamides or penicillin. Since we have one case which we have treated successfully we feel that it should be brought to the attention of the medical profession, trying to show that such cases are not all hopeless but should have the benefit of the newer treatment even though not always successful.

## CASE REPORT

The patient in question was admitted to this hospital on November 27, 1943, at which time she gave a history of having vague attacks of mild daily fever, chills, anorexia, and mild edema of the lower extremities, for three months. There had been a loss of weight of 15 or 20 pounds. Her past history was essentially negative throughout. General physical examination revealed a well developed, fairly well nourished white female lying quietly in bed acutely ill. Her lungs showed crepitant rales at both bases and apices. The heart was regular in rate and rhythm but there was a loud rasping diastolic murmur heard over the mitral area and transmitted to the axilla. The heart was not enlarged. Blood culture was taken on the day following admission which showed the presence of streptococcus viridans. The usual treatment was instituted which consisted of supportive measures and sulfonamides. The temperature remained elevated daily and ranged from 99.2° to 102.2°. Small repeated blood transfusions were given until a total of 15 250 cc. transfusions of whole blood had been administered over a period of 62 days.

During this entire time the sulfonamides were continued. On the 74th day in the hospital penicillin was begun. During the entire stay in the hospital up to this time the temperature continued to run a septic course. The sedimentation rate was elevated to 16 mm. per hour. The original dosage of penicillin was 15,000 units every three hours day and night. At 7:00 A. M. on the morning of the 75th day the patient's temperature returned to normal and remained there until the 82nd day. On the 82nd day the temperature reached 99° and then returned to normal. On the 83rd day the dosage of penicillin was cut down to 10,000 units every three hours during which time the temperature rose to 99° every afternoon. On the 86th day the dosage was reduced to 5,000 units every three hours and the temperature continued to rise to 99° in the late afternoon. On the 88th day we again administered 15,000 units every three hours and the temperature returned to normal in five days and has remained normal since then. The medication was stopped on the 97th day.

The opinions or assertions contained herein are the private ones of the authors and are not to be construed as official or as reflecting the views of the Navy Department or the Naval Service at Large. Submitted August 26, 1944.

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A total of 2,430,000 units of the drug was given over a period of 23 days. During this time the patient's general condition improved miraculously, appetite increased, nervousness decreased, and recovery was started. During the convalescence, after the drug was stopped, there was one period, on the 111th day of hospitalization, when the patient's temperature rose to 100 degrees, which was due to a low grade phlebitis in one of her legs. She was dismissed 129 days after admission. The blood cultures were negative and had been negative since five days after the institution of penicillin treatment. The patient's blood count returned to a normal level and the kidneys showed no involvement.

It is noted from the above table that the blood count was held at approximately a stationary level before the use of penicillin only by the repeated small transfusions. After penicillin was instituted, in order to evaluate the use of the drug, all other medication was stopped. It is noted now that the blood count remained at a stationary level probably due to the sterility of the blood stream.

Fifty days after discharge this patient was readmitted and was again studied for the infection. Electrocardiogram was normal, sedimentation normal, the blood culture was negative.

Six weeks later she again came under our observation and was found to be normal at that time. The heart murmurs had not changed, nor did we expect them to change.

Two hundred and forty-five days after admission to the hospital the patient was again examined and her blood count was 3,630,000 with 6,100

## A SUMMARY OF THE LABORATORY FINDINGS

| Day of Hospitalization | Blood Culture  | Trans-fusion | RBC  | WBC  | Hgb  | Urine    | Agglutination Series | Sedimentation Rate |
|------------------------|----------------|--------------|------|------|------|----------|----------------------|--------------------|
| 1                      | Strep Viridans |              | 3.18 | 7550 | 9.5  | Neg.     |                      |                    |
| 4                      | " "            |              |      |      |      |          | Neg.                 |                    |
| 7                      | " "            |              |      |      |      |          |                      |                    |
| 11                     |                |              | 2.72 | 8750 | 8.5  |          |                      | 29                 |
| 13                     |                | 250          |      |      |      | Neg.     |                      |                    |
| 15                     |                | 250          | 3.94 | 7300 | 10.5 |          | Neg.                 |                    |
| 22                     |                | 250          | 3.59 | 9400 | 11.0 | Tr. Alb. |                      | 25                 |
| 25                     | " "            | 250          |      |      |      | Neg.     |                      |                    |
| 28                     | " "            | 250          | 3.79 | 5050 | 11.5 | Neg.     |                      |                    |
| 32                     |                | 250          |      |      |      |          |                      |                    |
| 35                     |                | 250          |      |      |      |          |                      |                    |
| 39                     |                | 250          | 4.07 | 9550 | 12.5 | Neg.     |                      | 15                 |
| 42                     |                | 250          |      |      |      |          |                      |                    |
| 46                     |                | 250          |      |      |      |          |                      |                    |
| 51                     |                | 250          |      |      |      |          |                      |                    |
| 53                     |                | 250          | 3.94 | 7250 | 12   | Neg.     |                      | 16                 |
| 58                     |                | 250          |      |      |      |          |                      |                    |
| 60                     |                | 250          |      |      |      |          |                      |                    |
| 64                     |                | 250          | 3.64 | 5600 | 11   | Neg.     |                      | 20                 |
| 67                     |                | 250          |      |      |      |          |                      |                    |
| 71                     |                | 250          |      |      |      |          |                      |                    |
| 74                     | " "            |              | 3.84 | 7150 | 11.5 | Neg.     |                      | 15                 |
| 79                     | Negative       |              | 3.93 | 6600 | 11   | Neg.     |                      | 13                 |
| 81                     | "              |              |      |      |      |          |                      |                    |
| 83                     | "              |              | 3.67 | 7600 | 11   | Neg.     |                      |                    |
| 85                     | "              |              | 3.87 | 7600 | 11   | Neg.     |                      |                    |
| 88                     | "              |              |      |      |      |          |                      | 19                 |
| 95                     | "              |              |      |      |      | Neg.     |                      |                    |
| 98                     | "              |              |      |      |      | Neg.     |                      |                    |
| 102                    | "              |              | 3.96 | 9550 | 12   | Neg.     |                      |                    |
| 109                    | "              |              | 3.86 | 6450 | 11.5 | Neg.     |                      |                    |
| 116                    | "              |              | 3.84 | 6150 | 11.5 | Neg.     |                      |                    |
| 125                    | "              |              | 3.99 | 6350 | 12   | Neg.     |                      |                    |

white cells and 11 gms. of hemoglobin. The differential count was within normal limits. Her sedimentation rate was 11 mm. per hour. Blood culture was negative, electrocardiogram was negative except for left axis deviation. Chest X-ray showed the lung fields to be clear and the heart of a mitral type. She has no complaints and is

leading a normal life except that excessive activity has been restricted. We feel that this case does show a cured blood stream infection which was brought about solely by the use of penicillin. Because of our success on this case we feel that penicillin should be used in similar cases even though the results are not uniformly successful.

### Industrial Hazards

The type of exposure which is most hazardous with the possible exception of active skin poisons, is that of inhalation of dusts, fumes, or gases. While accidental ingestion of inorganic poisons is comparatively rare, apparently poisoning as a result of this type of exposure is more generally familiar than that of inhalation. As a matter of fact, poisoning from the ingestion of the toxic materials of industry is less frequent because of the hygienic facilities of large establishments and because of increased awareness of both employer and worker with regard to cleanliness. Apart from this, absorption from the alimentary tract is by no means complete especially with many insoluble substances. An adequate diet also may tend to decrease absorption as for instance in the case of lead where a high calcium diet markedly increases lead absorption.

From an historical point of view the severe

lead poisoning resulting from drinking wine sweetened with lead (Citosis, 1616), from Devonshire cider (Hardy, 1778), from Jamaica rum (Hunter, 1778) and the many cases since then of poisoning resulting from drinking water or eating food heavily contaminated with lead has probably overshadowed other means of causing lead poisoning, yet the greater danger of breathing lead dust or fume was pointed out more than a century ago by Tanquerel des Planches (1839) and by many others since. Minot found that as much lead may be absorbed from the respiratory tract in one day as may be absorbed from soluble ingested lead over a long period of time. Hence the individual's injury is likely to be much greater than when exposed to dust, fume, or gas by inhalation than when he is receiving the same amount of material by mouth.—Lawrence T. Fairhall, Ph.D., Bethesda, Md.; Conn. State Med. Jr., Vol. IX, No. 2, Feb. 1945.



# Alleviation of Anxiety During Pregnancy

## A Series of Answers To Questions Most Commonly Asked By Patients\*

LEONARD H. BISKIND, M.D.

IN the course of a year, a record was kept of all the questions asked by obstetric patients. Those most often associated with anxiety were found to be related to labor, delivery and the puerperium. Ideally, the solution for such a problem rests in the proper development of a friendly understanding between patient and physician. Since the war has brought increasing responsibilities and larger practices to civilian physicians, it has become almost impossible to give each patient the required time for more than routine prenatal procedures.

For this reason a temporary method had to be found to replace verbal discussions between patient and physician. The author felt that it might prove efficacious for his patients, particularly those in whom marked anxieties existed, if he prepared in written form a series of explanations covering labor, delivery and the puerperium.

Accordingly, a summary of the procedures and instructions relating to these subjects was given to each patient during her ninth month of pregnancy. In general this summary was exceptionally helpful. In most cases fears subsided and anxieties were allayed.

Since it may prove of value to other members of the profession at the present time; this material is presented here.

### LABOR AND DELIVERY

1. Labor "pains" are the contractions of the womb which force the baby through the birth canal.

2. Ordinarily, labor begins with irregular pains either in the lower back, across the abdomen, or both. Some women experiencing labor pains for the first time refer to them as resembling severe menstrual cramps.

3. These pains may first come at irregular intervals for several hours; these intervals may range from ten to thirty minutes or more. Gradually the intervals between the pains shorten, the duration of the pain is longer, and the intensity is greater.

4. Usually associated with labor pains there is what is called "bloody show". Normally there is a plug of mucous in the neck of the womb which keeps the contents of the womb sealed off during pregnancy. When labor begins this plug is expelled and often mixes with a small

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quantity of blood giving the discharge a reddish brown color. When found in conjunction with regular labor pains, bloody show is indicative of active labor.

5. Occasionally during the last month of pregnancy patients will have abdominal and back pains strongly suggestive of labor. After several hours they usually disappear and in general there is no associated bloody show. These are termed "false labor pains".

6. If this is your first baby go to the hospital when your pains have been coming at regular five to eight-minute intervals for a period of two hours. If this is a subsequent pregnancy, go to the hospital as soon as your pains reach the five to eight-minute cycle.

7. You can guide yourself to some extent with the knowledge that with the first baby labor lasts from 12 to 24 hours, often longer; with subsequent babies labor may last six to 12 hours, sometimes more but often less. Some thought should be given to the distance from the hospital that you may live, the availability of transportation when needed, and the length of time it takes you to get there.

8. Should you break your bag of waters, go to the hospital at once at any time of the day or night. Do not wait for labor pains. Do not be disturbed by well meaning friends who will tell you that a dry labor is a very difficult one. This may or may not be true in any given case and depends on many factors. The purpose of going to the hospital immediately on breaking of your bag of waters is to prevent possible infection. This is done by routine installations of an antiseptic into the vagina at regular intervals prior to delivery.

9. During the last month of pregnancy no tub baths should be taken. In particular, when labor begins or you break your bag of waters do not take a bath.

10. In view of the fact that your obstetrician believes in repairing the birth canal immediately after delivery whenever possible, you will receive an anaesthetic at the time of delivery. If there

\*From the Departments of Obstetrics and Gynecology, Mount Sinai Hospital, Cleveland, O. Submitted Sept., 1944. Paper condensed for publication; appears in full in author's reprints.

is food in the stomach you may vomit, thus interfering with the delivery and subsequent repair. In addition, there is always danger of obstructing air passages by mucous or vomited food. Therefore, when labor begins do not eat any food. If in doubt, consult your physician.

11. On arrival at the hospital you will be admitted, assigned to a labor room, prepared and shaved for delivery and examined by the house physician. The latter will inform your obstetrician of your condition, the state of your labor and the position and condition of your baby. Shaving of the perineal area and the subsequent use of an antiseptic over the abdomen, thighs, and perineum (at delivery) is essential in order to avoid infection.

12. It is unnecessary for you to telephone your obstetrician or the hospital when you are ready to be admitted. Merely go to the hospital. If you have hospital insurance be sure to take with you the number of your policy for presentation to the admitting officer. If you do not have hospital insurance, be certain to have available funds either in cash or a check for the necessary payment for admission. Do not bring any valuables such as jewelry with you; sleeping garments and toilet articles are all that is necessary.

13. Should you have bleeding from the vagina at any time during labor do not wait for regular pains but go to the hospital at once. Abnormal vaginal bleeding during labor might require quick action on the part of your obstetrician. As a result you should be in the hospital under the watchful eye of the nursing and house staff.

14. In all probabilities you will receive some form of "twilight sleep" at the proper time during labor. When you are to receive relief from pain is dependent upon the position of the baby, the length of your labor, and the extent of the opening of the neck of the womb. If given too soon it will delay and probably stop labor; if given too late it may affect the baby. Sometimes it is not possible to give a patient any form of "twilight sleep" particularly if she does not come to the hospital in sufficient time or if the labor is unusually rapid. Caudal anaesthesia may be available to certain selected cases.

15. As a routine measure all patients are given Vitamin K hypodermically upon admission. This serves the purpose of lessening the dangers of excessive bleeding at and following delivery and helps to prevent certain birth injuries to the baby.

16. Ordinarily you will receive no food nor water during labor. If your labor is prolonged you will receive a sedative and will be given a sugar and salt solution into a vein. This serves the purpose of allowing you to recover your strength for the additional period of labor you may have to undergo.

17. Visitors are not permitted to see you while you are in labor. This includes your husband and all members of your family. Inform them that it is not necessary for more than one or two to remain at the hospital awaiting your delivery. Too many visitors creates considerable confusion particularly for the nursing staff.

18. Please remember that no two labors are alike. They vary in the same patient and for reasons beyond your control. Remember also that nursing and medical house personnel vary each year. They are present not only to serve you but to learn as well. Please treat your nurses and your house physicians as fellow human beings whose primary interest is to be of assistance to you. Certain procedures and examinations must be made at intervals so that your obstetrician can be kept informed of the progress of your labor. Your cooperation in these matters is expected.

#### HOSPITAL CARE AFTER DELIVERY

1. Upon the birth of your baby your obstetrician ties and severs the umbilical cord. Occasionally he will cleanse the baby and if necessary, gently stimulate it to regulate respirations.

2. The baby will be handed to a nurse for further care and placed in a tilted basinet with the head lowered so that mucous usually found in the air passages may be removed with an apparatus for that purpose. When the respirations are normal and the cry is lusty the nurse will complete the cleansing of the baby using baby oil and a soft gauze sponge. Several drops of a special antiseptic will be instilled into the baby's eyes. This procedure is required by law as a preventive of an infective condition in the eyes of the newborn. Finally the baby's last name, in beads (prepared while you are in labor) is checked, double checked, and clamped around the baby's neck.

3. While the nurse is caring for the baby your obstetrician is completing your delivery and repair.

4. Upon completion of your delivery you will be transferred from the delivery table to your bed and kept in the delivery room under the watchful eye of a nurse until you react completely from the anaesthetic. This takes about two to three hours. You will then be removed to your room.

5. Your obstetrician will then show the baby to your husband after which it will be placed in the nursery. There it will be thoroughly examined, weighed, measured and properly dressed. You will receive a card from the nursery indicating the sex of your child, date and time of birth, length and weight.

6. With the diminution of nursing personnel as a result of the war, your care during your stay in the hospital will be good, but devoid of



all luxuries. As soon as possible you will be asked to help yourself with your daily care. Sponge baths and perineal care will be given at regular intervals by the nurse. Bedpans will be distributed at required intervals by nurses or their aides.

7. Most patients are urged to drink fluids, particularly water, the first few days following delivery in order to stimulate bladder tone and activity. In recent years it has become routine to instill a small amount of a weak antiseptic solution into the bladder at the time of delivery. This serves to stimulate the bladder so that you may void normally. Occasionally, it is necessary to catheterize a patient. This is done under strictly aseptic conditions and need not be either painful or uncomfortable. Enemas are given routinely on the second day after delivery. A mineral oil preparation is used as an intestinal lubricant and nothing stronger than milk of magnesia is used as a laxative when necessary.

It is extremely important for obstetric patients to use caution in proper cleansing of the rectal and urethral areas. Following bowel movement the rectum must be cleansed from the rear only and never by a forward upswing motion between the thighs. Following urination, the vaginal outlet should be dried by absorption as in the use of a blotter. A pitcher douche consists of the separation of the lips of the vagina and the gentle pouring of comfortably warm water over the vaginal opening.

8. Visitors are limited in all hospitals, particularly in the maternity pavilions, for reasons of security. Visitors may be a potential source of infection not only to yourself and indirectly to your baby but to other patients on the maternity pavilion as well. For this reason you will only be permitted to see your husband and your parents during your stay at the hospital. Visiting on the maternity ward is by appointment only. Babies cannot be shown to visitors and no one other than the nursing and physician personnel are permitted on the maternity ward while babies are nursing.

9. Ordinarily, milk appears in your breasts about 48 to 72 hours after the birth of a baby. It is to the baby's advantage for you to nurse it as long as possible. In most cases mother's milk is still the new-born infant's best food. Remember that all babies who nurse at the breast obtain 90 per cent of their feeding in the first 10 minutes; the rest of the time they play or sleep or use the nipple as a pacifier. Train your infant so that it need not be kept at the breast for more than 15 minutes at any feeding. Your nipples will be given care before and after each feeding. Cracked or bleeding nipples will get special attention.

10. It is preferable that you have a pediatrician for your baby in attendance before leaving the

hospital. In this way you can establish an early relationship with a qualified physician who will assist you in the problems of caring for your infant. Should you, for any reason, be unable to nurse your baby, your breasts will be dried, following a standard routine procedure. Your baby will receive a feeding formula as advised and outlined by your pediatrician.

11. After you recover from the anesthetic and have been removed to your room you will receive a sedative for several hours of refreshing sleep. On awakening, you will be advised to turn from side to side at intervals during the day. While in the hospital exercises of any special type are unnecessary. Abdominal binders are no longer applied to patients since they have been found to serve no useful purpose.

12. Since, in all probabilities, you will have stitches, you may require some relief from discomfort. Report such discomfort to your house physician or to your obstetrician. Often patients anticipate the removal of the stitches with considerable anxiety and fear, because of expected pain in that connection. Only absorbable sutures are used and as a result need not be removed.

13. You will receive plenty of well balanced, well cooked nourishing food especially prepared for maternity patients. It is inadvisable for visitors to bring you delicacies in the form of candy and fruit. Such additional calories merely serve to put on unnecessary weight.

14. Nurses and their aides must take time from the essential care of patients to assist in the delivery of gifts, packages, flowers and plants. Advise your well meaning friends and relatives to send as many of these as possible to your home instead of to the hospital.

15. Normally throughout your stay in the hospital there will be a bloody discharge from the vagina, resembling a light menstrual flow. A heavy flow or clots should be reported to the nurse or the house physician at once.

16. "After pains" result from the contractions of the womb which persist following delivery. Ordinarily these are not felt by women having their first baby. They are common after subsequent deliveries and often most pronounced while nursing. They usually disappear in three to five days. When necessary medication is given for relief particularly at night to permit a restful sleep.

17. Experience during the war has indicated that it is neither advisable nor necessary to keep maternity patients in bed from 14 to 21 days. On the contrary, it appears that patients may go home in an invalid car within seven days, have bathroom privileges as soon as they reach home, and be up for their meals regularly by the tenth day after the birth of the baby. There is also reason to believe that patients

maintaining adequate doses of vitamin B complex throughout pregnancy are able to be up and about much sooner and with less danger of abnormal bleeding.

18. If your baby is born by caesarean section you will be considered primarily as a surgical patient, secondarily as a maternity patient, and treated accordingly.

#### HOME CARE AFTER BEING DISCHARGED FROM THE HOSPITAL

1. Since your stay on the maternity pavilion is of necessity limited as a wartime measure, it is advisable that you go home in an invalid car. Have your husband or some member of your family make the necessary arrangements through the floor secretary or the head nurse in charge of the ward.

2. Unless otherwise instructed you may have bathroom privileges after your arrival at home. Have your nurse, or some member of your family accompany you for the first day or so, as you will be rather weak.

3. Except for bathroom privileges, you are to remain in bed for three days, having all your meals in bed.

4. On the fourth day, you may get up for your meals. If your residence is entirely on one floor, you may walk to the dining room or kitchen, have your meal leisurely, and then return to bed. On the fifth and succeeding days, you may stay up an additional 15 to 30 minutes after the completion of each meal so that on or about the fourteenth day after you arrive home, you should be strong enough to take care of the baby. If your home is on two floors, have a card table set up in your bedroom or an adjoining room, so that you may sit up for your meals after the third day.

5. You are not permitted to walk up or down steps for four weeks after the birth of your baby.

6. It is advisable to wear a good fitting, comfortable girdle as soon as you are up and about the house.

7. No douches and no tub baths are permitted for six weeks, unless authorized earlier by your obstetrician. A sponge bath and pitcher douche may be taken as often as twice daily if desired. A spray shower may be taken daily when the bloody flow stops. At the time of your final examination ask your obstetrician for instructions regarding the proper method of douching.

8. The bloody discharge may last from 10 to 14 days or longer. It may increase in amount on arising, or when you have been on your feet. The first menstrual period after the birth of a baby is usually heavier and longer than normal. This might require bed rest. Report any period which lasts longer than seven days to your

obstetrician. The first period after having a baby usually is delayed until the mother stops nursing. If no nursing takes place, the first period usually appears within 90 days.

9. Eat a normal, well balanced diet of meat and vegetables with a minimum of starch and carbohydrate foods; it is not necessary to eat excessively to produce milk. Milk is produced by the action of certain glands. If these glands function normally, you will have milk; if not, no amount of food will produce milk; you will merely put on weight.

10. Do not have too much company the first two weeks at home. Learn to advise well-wishing friends and members of your family not to stay late; that long visits can be exhausting emotionally. Emotional exhaustion may be as detrimental to your health as physical exhaustion.

11. Until you redevelop your normal habits of bowel evacuation, use a lubricant such as a mineral oil preparation, daily (one tablespoonful at bedtime). Try to develop proper habit time of bowel evacuation once or twice daily at definite intervals.

12. When the baby is five weeks old, call your obstetrician's office for an appointment for your final examination.

13. For problems in connection with your baby, breast or bottle feeding, formulas and the like, please consult your pediatrician.

14. If you have taken vitamin B complex during pregnancy, continue to do so until you receive further instructions from your obstetrician.

15. Remember that the three to four-week period following the birth of your baby is an important one. You must take advantage of all the help and rest you can obtain. Do not overwork! Do not tire yourself physically or emotionally! On the other hand, do not shirk your normal responsibilities as a mother and expect to be treated as a china doll just because you had a baby.

16. If you have had a Caesarean section, some changes will be made in these instructions.

17. Do not hesitate to call your obstetrician if you have an important symptom to report or an important question to ask. However, please respect his time. Do not call him unless it is really urgent.

18. For conditions not associated directly with your pregnancy, consult your family physician.

19. Exercises are not necessary. Some patients accustomed to daily calisthenics may continue such exercises after the stitches have healed and the bloody flow has stopped. If your obstetrician finds that your womb is tipped when he examines you at your final examination, he may suggest knee-chest exercises twice daily. These will be demonstrated to you at the proper time.



# Anesthesia In Thoracic Surgery\*

NORRIS E. LENAHAN, M.D.

**A**NESTHESIA in thoracic surgery as practiced at University Hospital is limited to cyclopropane, oxygen, helium, and ether.

In discussing anesthesia in chest surgery we are dealing with a different type patient than the average surgical case. These cases usually show prolonged toxemia or amyloid disease and require an anesthetic of low toxicity and high oxygen concentration. Their vital capacity is usually seriously decreased and there is usually much sputum and often blood in their tracheo-bronchial tree.

The anesthetist then is concerned with the following problems:

1. To provide adequate oxygenation and relaxation.
2. To prevent a paroxysm of coughing.
3. To prevent paradoxical respiration.
4. To provide an open airway and the means to aspirate mucous and blood from the tracheal tree.
5. To carry out or supervise continuous circulatory resuscitation by means of fluids such as glucose, saline, plasma, or blood.
6. To maintain efficient respiration, under pressure if need be.

## ROUTINE PREOPERATIVE TREATMENT

A thorough routine preoperative check-up is made on each patient consisting of the following:

- a. Bronchoscope and lipiodalization.
- b. Sputum examination.
- c. Blood and urine.
- d. Vital capacity.
- e. Bun, PSP, Congo Red.
- f. Postural drainage—20 minutes Bid, day of operation, 1 hour.
- g. Ekg—if any doubt of cardiac status.
- h. In those with much sputum—several bronchoscopic aspirations, instil sulfathiazole.

Following these examinations the patient's status is decided upon as to operative risk and chance of success. Consultation with the anesthetic department as to the premedication and type of anesthesia is next in order.

Without entering into the highly controversial

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matter of which is the best anesthetic to use we will simply say that in our hands cyclopropane-oxygen-helium-ether seems to be entirely satisfactory.

Dr. Beecher<sup>1</sup> at Massachusetts General Hospital advocates the use of ether over cyclopropane and has written several excellent articles on this subject. He states in his article that the oxygen content is higher with ether, there is less strain on circulatory system, because cyclopropane has a toxic effect on the heart. He also states that ether undoubtedly irritates the mucus membranes more than cyclopropane but that cyclopropane is not without some irritation evidenced by salivation and occasional laryngeal spasm.

In our own experience cyclopropane induction is usually quick, smooth, and free from excitement. Occasionally one finds a patient who continues to cough, hack or hold his breath and in these cases we use sodium pentothal for an inducing agent, then cautiously add cyclopropane-ether until the proper depth of anesthesia has been reached for intubation.

Our technique following premedication with morphine 1/6-1/4 and scopolamine 1/150-1/200, depending on the age and size of patient and a nembutal if necessary for apprehension, is as follows:

The bag is half filled with oxygen and helium. Then cyclopropane-oxygen-500 cc. each is run in for 3 minutes. Helium 150 cc. per minute is allowed to trickle into the bag, at the end of 3 minutes a reduction of cyclopropane and oxygen to 300 cc. for another 2 minutes. Ether is then added and the patient is anesthetized to the 3rd stage, 3rd plane. Cyclopropane is then reduced to maintenance dose.

By the use of the laryngoscope a woven catheter endotracheal tube with an inflatable cuff is then inserted into the trachea. The cuff is then inflated and the proper connection utilized to con-

\*From the Department of Anesthesia, University Hospital, Columbus, Ohio. Aided by grant from Comly Fund of Ohio State University.

Presented at the Annual Meeting of Ohio Society of Anesthetists, held in conjunction with the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Columbus, May 2-4, 1944.

nect with a Connell anesthetic machine which has a spirometer attachment. This then is a circle filter closed endotracheal technique.

The depth of anesthesia after the skin incision is made, may be lightened and simply maintained below the cough reflex.

Intravenous fluids in the form of saline and glucose is then started as a slow drip. Instantly plasma or blood may be given without hunting for collapsed veins in a crisis, by simply substituting plasma or blood for the saline.

Novacaine is of value to infiltrate the periosteum of the ribs prior to stripping them. By so doing stimulation of respirations are not so pronounced, or, as occasionally happens, stop altogether for a few seconds.

In pneumonectomies and lobectomies, novacaine is injected into the hilus of the lung to block the vagus and its pulmonary plexus; the phrenic nerve also may be injected if necessary.

With an open pneumothorax, positive pressure is very desirable for the following reasons:

1. Prevention of collapse of the contra lateral lung.
2. Frequent re-inflation of collapsed lungs to prevent lung edema which is the probable result of anoxemia.
3. Demonstration of anatomical landmarks or lines of demarkation in lobectomy.
4. To stabilize the mediastinum and prevent paradoxyical respiration.
5. To provide a means to properly re-inflate the lung at the time of closure of the chest.

During the operation positive pressure is usually maintained at 8-20 mm. pressure.

A word concerning the use of intratracheal tubes. Here at University Hospital a woven catheter is used with an inflatable cuff. We use intratracheal anesthesia in lobectomy, pneumonectomy, operation for patent ductus arteriosus, and for splanchnic resection.

Intratracheal tubes have two functions: (1) To insure an open airway, and allow positive pressure; (2) to permit thorough and immediate aspiration, which may be life saving.

An excellent monograph on "Endotracheal Anesthesia" by Dr. Noel Gillespie has recently been published and I advise all of you to read this interesting book.

Dr. Beecher<sup>1</sup> is of the opinion that inflatable cuffs are not necessary. He states that often a profuse drainage from the diseased lung will trickle into the trachea at a slow rate, so that it is impossible to pick up much of it through the intratracheal tube. In the absence of the inflatable cuff much of this slow drainage follows along the outside of the tube and into the face mask, since the patient is in the face down position. With an inflatable cuff this is impossible

and the spillage enters the good lung. He also thinks a cuff damages the mucosa or its delicate ciliary apparatus making it ineffective at least temporarily.

In our own cases we use an endotracheal tube with an inflatable cuff and have had uniformly good results.

In analyzing our cases as to age groups, we found the greatest case age came in the 20-29 year olds as shown by the following chart:

| Age     | No.  | Per Cent |
|---------|------|----------|
| 0- 9 =  | 3 =  | 5.2      |
| 10-19 = | 7 =  | 12.4     |
| 20-29 = | 19 = | 34.7     |
| 30-39 = | 6 =  | 10.6     |
| 40-49 = | 8 =  | 14.2     |
| 50-59 = | 8 =  | 14.2     |
| 60-up = | 5 =  | 8.7      |
|         | 56   | 100.0    |

The youngest operated on was 7 years old. The oldest was 67 years old.

Time of Operation:

- Range —1 hour 25 minutes to  
—4 hours 55 minutes  
Average—2 hours 34 minutes  
(K) Average—2 hours 6 minutes  
(C) Average—3 hours 39 minutes

The following chart will show the type of operation performed and the indication for the operation:

LOBECTOMY—BRONCHIECTASIS

|                                 |    |
|---------------------------------|----|
| 1. Left upper .....             | 2  |
| 2. Left lower .....             | 23 |
| 3. Right lower and middle ..... | 2  |
| 4. Right lower .....            | 5  |
| 5. Right middle .....           | 3  |
| 6. Right upper .....            | 1  |
|                                 | 36 |

LOBECTOMY—BRONCHIECTASIS

|                                         |    |
|-----------------------------------------|----|
| 1. Right—abscess of bronchiectasis..... | 7  |
| 2. Right—carcinoma .....                | 2  |
| 3. Left—abscess .....                   | 2  |
| 4. Left—non-specific pneumonitis.....   | 1  |
|                                         | 12 |
| Exploratory thoracotomy.....            | 7  |
| Pneumolysis .....                       | 1  |
| Splanchnic resection .....              | 1  |
| Rib resection .....                     | 1  |
| Lingulectomy .....                      | 1  |
|                                         | 11 |



The total number of cases operated on in the past 18 months, and their ultimate result is as follows:

|                             |    |
|-----------------------------|----|
| Total number of cases.....  | 59 |
| Total number of deaths..... | 13 |
| Total number recovered..... | 46 |

DEATHS

|                                                               |              |
|---------------------------------------------------------------|--------------|
| *Respiratory failure, massive atelectasis .....               | 1            |
| Septic embolus, brain abscess.....                            | 1 (34th day) |
| Metastatic abscess, brain.....                                | 1 (36th day) |
| Empyema .....                                                 | 1 (76th day) |
| Rupture aortic aneurysm .....                                 | 1            |
| Expired 12th day, carcinoma .....                             | 1            |
| Pulmonary embolism, massive collapse .....                    | 1            |
| *Central anoxia .....                                         | 1            |
| Hemorrhage left pleural cavity (6 hr. P.O.) .....             | 1            |
| *Profound shock, last 2 hr. for 4 hr., expired 2 hr. P.O..... | 1            |
| *Shock—very nervous 45 min. after O.R. ....                   | 1            |
| Hemoptosis—12th day, massive hemorrhage .....                 | 1            |
| Air embolus .....                                             | 1            |
| Deaths that could be attributed to anesthesia .....           | 4            |
| making a mortality of.....                                    | 6.7%         |
| Deaths that could be attributed to Surgery                    | 12%          |

COMPLICATIONS

|                                                                       |   |
|-----------------------------------------------------------------------|---|
| 1. Operative wound infected.....                                      | 1 |
| 2. Atelectasis—left upper lobe .....                                  | 1 |
| 3. Massive collapse in remaining lung resulting in death .....        | 1 |
| 4. Empyema .....                                                      | 9 |
| 5. Broncho pleural fistula .....                                      | 2 |
| 6. Brain abscess .....                                                | 1 |
| 7. Pneumonia .....                                                    | 1 |
| 8. Pulmonary hemorrhage .....                                         | 3 |
| 9. Shock and death .....                                              | 2 |
| 10. Severe congestion of remaining lung following pneumonectomy ..... | 1 |
| 11. Rupture aortic aneurysm.....                                      | 1 |
| 12. Tension pneumothorax .....                                        | 1 |
| 13. Air embolism—death .....                                          | 1 |

SUMMARY

A review of cases operated on at University Hospital in thoracic surgery for the past 18 months.

The type of anesthetic given and the method of giving it. The ultimate result as to recovery, post-operative complications, and death is given in chart form.

REFERENCE

1. Beecher, H. K. "Some Controversial Matters of Anesthesia for Thoracic Surgery" *Journal of Surgery* 10-292 Dec. 1940.

Adequate Diet

Attention is now focused on the question of the minimum nutritional need for protein, for now such physiologic and pathologic problems as growth, immunity, blood formation, wound healing, pregnancy, lactation, bone formation, edema, and liver diseases are known to be related to the amount and quality of protein in the diet. The specific need of protein nutrition is for the amino acids of which proteins are made, and different proteins—and thus different foods—vary in their content of the acids which are essential. While it was formerly thought that protein in itself was required to control many of these physiologic and pathologic effects, considerable evidence has accumulated that other constituents of protein foods, namely, minerals and vitamins, may account at least in part for many of them. Re-evaluation of protein's role has been stimulated by wartime needs for clarification, hence a considerable number of studies are being made at the present time. Knowledge of the dependency on protein in the diet for wound healing and blood formation is a contribution of considerable clinical importance at this time.

It should be kept in mind that protein foods and proteins are not synonymous. A high protein diet means high-protein foods which have, in addition to protein, other important nutrients such as minerals, vitamins of the B complex, fatty acids, and fat-soluble vitamins. There is general agreement that the present recommended dietary allowances for protein are fully adequate as applied to the usual mixed diets and are probably more generous than necessary with certain food combinations.

When a physician prescribes certain protein foods which are superior in amino acid make-up, he is confronted with the problem of whether it is economically possible for his patient to follow the prescription. As in the case of fat, protein of animal origin is expensive to produce in comparison to protein of vegetable origin. Certainly animal protein is the preferred source from the point of view of patient's choice, for we Americans are among the economically fortunate peoples of the world who have liberal intakes of animal proteins ingrained in our eating habits. On the other hand, Eastern peoples have subsisted fairly well for centuries on diets containing less than 10 per cent of their protein from animal sources. It is quite likely that the food experts of the United Kingdom when following the policy in the war emergency of recommending that the supply of animal protein should not fall below 40 gm. per day, or approximately one-half of the total needed protein intake, had in mind consumer morale as well as physiologic requirements.—Editorial, *New York State Jr. of Med.*; Vol. 45, No. 3, Feb. 1, 1945.

# Mycotic Aneurysm of the Sinus of Valsalva

CARL F. VILTER, M.D., and ROBERT J. RITTERHOFF, M.D.\*

Case 86206. W. W., a 43 year old colored male, was admitted to the Cincinnati General Hospital on November 12, 1943. He complained of shortness of breath which was of three weeks' duration.

**History:** Four weeks prior to admission the patient suffered from a respiratory infection characterized by a cough, productive of white sputum, and pleuritic pain in the right anterior chest. There was no hemoptysis. The pain gradually subsided. Four days after the onset of his present illness, he was stricken, while lifting a railroad tie, by a choking sensation, dyspnea, and sharp pain in the epigastrium. The pain radiated up the sternum, waxed and waned, and was not influenced by activity; it persisted for two weeks. The dyspnea continued after the abrupt onset and was followed rapidly by orthopnea and paroxysmal nocturnal dyspnea. Progressive edema of the legs appeared about one week after the onset. He experienced some palpitation and tinnitus with his episodes of paroxysmal dyspnea.

The past history revealed that at the ages of 7, 12, and 30 the patient had had attacks of polyarthritis characterized by red, swollen and tender joints. He recalled being more frequently short of breath in his youth than other children and of having frequent epistaxes. He had had the common childhood diseases, pneumonia during infancy, and typhoid fever. In adolescence he contracted gonorrhea, lymphopathia, venereum, and syphilis. For the last he had had treatment with heavy metals for two years. In 1938 a second degree burn brought him to this hospital and at that time a rough systolic murmur was heard at the cardiac apex and another systolic murmur in the aortic area. A chest teleoroentgenogram presented no abnormalities. An electrocardiogram revealed evidences of minimal "myocardial damage": left axis deviation. P.R.Q. 18, slurred QRS .08, and an inverted T.

In July of 1942 the patient had an illness of 10 days' duration which was characterized by dyspnea and pain radiating around the costal margins. There was no recurrence of this until the present illness.

**Physical Examination:** T. 99.2; P. 100; R. 24. The patient was a well developed and well nourished individual in obvious respiratory distress. Only the significant physical findings are recorded. The mucous membranes were normal and no petechiae were seen. A copious inspissated, mucopurulent discharge covered the posterior pharynx. The chest was symmetrical and the percussion note was hyporesonant over it. Scattered moist rales were present at the lung bases. The pulse was regular and the blood pressure was 192/74. There was marked cardiac enlargement to the left and the apical impulse was forceful. Widening at the base of the heart, where there was a systolic thrill, was thought to be present. A rough systolic murmur and a soft blowing diastolic murmur were heard at the

apex and were transmitted laterally. Loud harsh systolic and soft, high pitched diastolic murmurs were present at the base. These were transmitted into the neck vessels. The superficial lymph nodes were slightly enlarged. The liver, greatly enlarged, was symmetrical, firm, smooth, and moderately tender. There was considerable dependent edema, extending to the mid-thighs, and clubbing of the fingers and toes was prominent. The ankle jerks were not present.

**Laboratory Data:** Hemoglobin 13.3 gm.; erythrocytes, 4,970,000; leucocytes, 8,550 with 56 per cent neutrocytes; 35 per cent lymphocytes; 8 per cent monocytes; and 1 per cent eosinophiles; blood Kahn, positive; blood urea nitrogen, 13 mg. per cent; urine negative, except for + albumin; cerebrospinal fluid and pressure, normal; vital capacity, 62 per cent; decholin circulation time, 37 seconds; venous pressure, 16 cm. H<sub>2</sub>O. An electrocardiogram showed left ventricular preponderance, PR 0.42, QRS .09 and T<sub>s</sub> low voltage. Chest teleoroentgenogram revealed that the transverse diameter of the heart was 18 cm. (in a chest of 28 cm.). "The heart is enlarged to right and left. The aortic knob is slightly increased in density. The aortic window is partially obliterated by widening of the root of the aorta. Both hilar shadows are prominent with calcifications therein. The markings are generally increased throughout both lung fields, compatible with pulmonary congestion".

**Course:** With digitalis, nasal oxygen, morphine, and occasional administrations of mercurpurin and aminophylline I. V. the patient gradually became more comfortable. Dependent edema and congestive rales cleared; the liver shrank and dyspnea was abated. The vital capacity, however, did not improve. Blood pressure readings varied between 120/40 and 128/60. Fever was absent the first two weeks and the pulse varied only from 78 to 88. On the eleventh hospital day he was allowed up in a chair and promptly began to develop edema, hepatomegaly and dyspnea. The temperature rose daily to 100 or 101 degrees. Cardiac decompensation was progressive and by the twenty-fourth day he had regressed to his admission status. In addition, on the twenty-fourth day he complained of epigastric pain. An electrocardiogram showed an auricular rate of 77 and a ventricular rate of 41; the PR interval varied from 0.48 to 0.52. (2:1 heart block); the QRS was 0.12; and T 1-2 were diphasic. A blood culture was negative, and the leucocyte count was 15,000. Electrocardiograms on subsequent days showed lengthening of the PR interval up to .62 sec. with episodes of 4:3 and 2:1 block. Although digitalis was discontinued at the first evidence of heart block on the twenty-second day, this condition persisted.

During the nights of the patient's last seventy-two hours he experienced bouts of severe epigastric pain accompanied by prolonged dyspnea and hyperventilation. During these days, his respiratory rate varied between 28 and 40; and his pulse rate, between 58 and 68. On the twenty-seventh day the pain in the epigastrium was particularly severe and persistent. The liver was large and tender, and the leucocyte count at that time was 22,500. In his last twenty-four hours he had several convulsive seizures characterized by clonic

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This is the twenty-first in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.



movements, absent heart action, and apnea lasting 10 to 30 seconds. Recovery from each attack was marked by hyperventilation. Death occurred in such an attack.

**Clinical Diagnosis:** Rheumatic heart disease with cardiac insufficiency; (Aortic insufficiency and stenosis; mitral stenosis and insufficiency; heart block with Adams-Stokes syndrome;) cardiac insufficiency; possible subacute bacterial endocarditis; probable mesenteric embolus; asymptomatic syphilis.

**Necropsy (N-43-480)** was performed six hours post mortem. **Gross Examination:** The body was that of a well developed and well nourished black male. Externally, the only significant findings were slight clubbing of the nail beds and slight dependent subcutaneous oedema. The pleural, peritoneal, and pericardial cavities were obliterated by dense, tough, white adhesions. The organs, generally, were in their normal positions and relations. The heart weighed 650 grams, and presented marked dilatation of all chambers, particularly the right atrium and ventricle. The interventricular septum was intact and the ventricular endocardium, and that of the pulmonic and the tricuspid valves, was of normal appearance.

The aortic valve was moderately irregularly narrowed, as the left and adjacent portion of the right semilunar cusps were nodularly thickened, rigid, fused and contained small calcareous masses. Also, a tannish-pink, friable, conical mass, 10 mm. in height, was attached to the ventricular and aortic aspects of the posterior and adjacent portion of the right aortic semilunar cusps. The ventricular aspect of this vegetation did not implicate the adjacent mural endocardium; however, the aortic aspect extended into the posterior sinus of Valsalva. Here, there was a saccular dilatation, the posterior wall of which was formed by the interatrial septum. This saccular aneurysm bulged into the right atrium as a rounded smooth mass, 2.5 cm. in diameter, surmounted by a cluster of small warty tannish masses, and was located between the fossa ovalis and the orifice of the transverse coronary sinus. Section through the posterior wall of the aneurysm revealed that it was 3 to 4 mm. in thickness and that it consisted of dense white tissue, covered by right atrial endocardium and lined by friable pinkish-tan material.

The mitral valve and its chordae tendineae were slightly thickened, shortened and opaque. The coronary arteries were patent and presented an occasional small atheromatous plaque. The right coronary ostium was located just above the saccular aneurysm which did not impinge upon the lumen of the contiguous portion of the artery. The systemic aorta beyond the aneurysm presented only a few small atheromatous plaques.

The kidneys were of usual configuration, of increased size, and weighed 485 gm. together. Coronal sections disclosed thick tannish-yellow even cortices and columns of Bertini sharply demarcated from the pinkish pyramids. The other organs were grossly remarkable only for evidences of chronic passive hyperemia. The inferior border of the liver extended 10 cm. below the xiphoid in the midline and 6 cm. below the costal margin in the right mid-clavicular line. The domes of the diaphragm, anteriorly, were at the level of the sixth rib bilaterally. Lastly, a healed primary pulmonary tuberculous complex was present.

**Microscopic Examination:** Representative sections of the myocardium presented slight diffuse

interstitial fibrosis, epicardial fibrosis, and marked fibrosis of the musculature of the left atrium. The left atrial endocardium, also, was moderately thickened by collagenous connective tissue. The small coronary arteries and the vasa vasorum of the aorta were thickened and their lumens were irregular. The thickening was produced chiefly by a marked increase in vacuolated smooth muscle cells and to a lesser degree by small nodular intimal masses. All the heart valves except the pulmonic presented an increased amount of collagen, vascularization by vessels similar to those described in the myocardium and slight lymphocytic infiltration. No Aschoff bodies were observed. These changes were least evident in the tricuspid valve and most marked in the aortic, where in addition there were nodular, focally calcified, atheromatous masses.

The posterior aortic cusp presented marked fragmentation and necrosis of the focally calcified collagen and a thick covering of organizing adherent fibrino-purulent exudate. Similar changes were present at the base of the aorta in the region of the saccular aneurysm. The interatrial septum, the posterior wall of the aneurysm, consisted of a thick zone of collagen and fibroblasts permeated by numerous macrophages laden with hemosiderin, plasma cells, and lymphocytes. Throughout this zone were small islands of degenerating and necrotic myocardial fibers, some of which were suggestive of neuromuscular tissue. The overlying right atrial endocardium and the lining of the aneurysmal sac were covered by fibrino-purulent exudate. Colonies of organisms were difficult to demonstrate in many sections either of the involved valve or aneurysmal wall. A small colony of gram positive cocci, presumptively streptococci, was demonstrated deep within the exudate on the aortic valve. Cultures were equivocal in that a hemolytic staphylococcus aureus and a nonhemolytic streptococcus were found.

Throughout the lung framework there was a moderate increase in fibrous tissue with an associated slight lymphocytic and monocytic reaction. The pulmonary arteries presented moderate intimal thickening. The alveoli were dilated and contained varying amounts of extravasated blood cells, inspissated protein material and hemosiderin-laden macrophages. Focally, in the framework, there were irregular confluent small globular blue stained masses. These, presumable calcium deposits, were located between the walls of the capillaries and the alveoli. The kidneys, in addition to presenting evidences of a marked toxic nephrosis, contained similar calcium deposits, located between the capillary walls and the convoluted tubular epithelium. An occasional convoluted tubule contained a calcium cast. Other findings were: marked chronic passive hyperemia of the viscera, central zone hepatitis and necrosis, splenic follicular hyperplasia and necrosis, minimal generalized arterio-and-arteriosclerosis.

**The pathological diagnoses were:** Subacute non-hemolytic streptococcus aortic valvulitis and aortitis and associated mycotic aortic aneurysm with erosion of the interatrial septum; old rheumatic pancarditis (fibrosis of the aortic, mitral and tricuspid valves; chronic epicarditis with epicardial fibrosis; focal diffuse and perivascular myocardial fibrosis); cardiac hypertrophy and dilatation with chronic passive congestion of the viscera; diffuse chronic interstitial pneumonitis with chronic pulmonary emphysema; marked fol-



licular splenic hyperplasia; central zone hepatic necrosis with focal acute hepatitis; marked toxic nephrosis; minimal focal calcification of the lungs and kidneys, probably on basis of alkalosis; minimal generalized arteriolosclerosis and arteriosclerosis; obliterative pleural and peritoneal fibrosis.

#### DISCUSSION

This case again demonstrated the liability of previously damaged heart valves to bacterial endocarditis. Repeated series of observations have shown that in 70 to 80 per cent of all cases of subacute bacterial endocarditis some pre-existing damage to the endocardium is demonstrable.<sup>1,2</sup> Subacute bacterial endocarditis associated with an erosive intracardiac aneurysm is of unusual occurrence. Pirani<sup>3</sup> recently summarized 15 such cases in which the aneurysm terminally ruptured and reported two others in which rupture did not occur. Rantz<sup>4</sup> and Knoll<sup>5</sup> each report a similar case. The formation of an erosive (mycotic) cardiac aneurysm is usually the result of bacterial valvulitis and less frequently the result of septic myocardial infarcts or abscesses.

Spread of the valve lesion to the base of the aorta or to the adjacent mural endocardium with attendant destruction will permit the blood impact and flow to excavate and dilate the affected region. Once initiated, the aneurysm will increase in size by virtue of continued bacterial activity and the greater lateral hydrodynamic forces existent in an aneurysmal sac. Dependent upon the location of the destructive process, the aneurysm will present or perforate into the pericardial sac, the pulmonary aorta, or the right atrium, that is with involvement of the right anterior, the left anterior, or the posterior aortic cusps respectively. Those involving the mural endocardium usually present through the septum membranaceum.

Subacute bacterial endocarditis, in contrast to acute, is usually not associated with terminal perforation of the aneurysm.<sup>3,6</sup> With atrial or ventricular septal erosion there is usually interruption of the neuromuscular tissue. In this case then, the massive destruction of the interatrial septum in the region of the S-A node, superimposed on focal rheumatic myocardial fibrosis, readily explains the clinical and electro-cardiographic findings of impaired conduction. The enlarged heart is attributable to hypertrophy as a result of rheumatic pancarditis and hypertension as evidenced by generalized arteriolosclerosis, and to dilatation concomitant upon further embarrassment of the aortic valve and the toxic effects of the infection upon the myocardium. The saccular erosive aortic aneurysm accounts for the X-ray demonstration of obliteration of the "aortic window" with apparent widening of the base of the aorta.

The lack of old or recent embolic phenomena is difficult to understand in view of the strategic

location of the lesion. Organization of the thrombotic material, eddies in the aneurysmal sac, and apparent low virulence of the streptococci are suggestive factors. This lack of embolic phenomena in occasional cases of bacterial endocarditis, particularly in those caused by streptococci of the enterococci group, has been commented upon by others.<sup>1,4</sup> Although apparently the organism was of low virulence marked toxic changes were present in the liver, spleen and kidneys. Perhaps, then, it would be better, in view of the marked attempts at healing and the lack of metastatic lesions, to consider the soil as highly resistant.

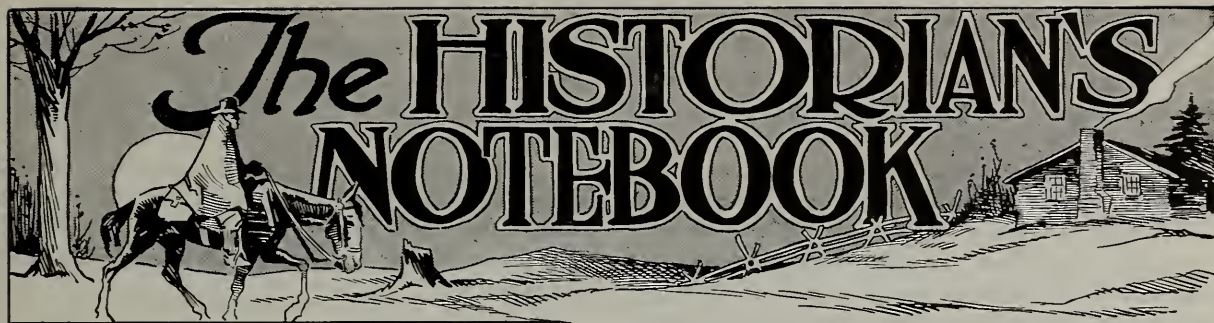
This case, also, demonstrates the difficulties in evaluating sulfonamide therapy, for if it had been used the extreme paucity of organisms in sections of the involved valve and the marked attempts at healing could have been cited as evidence of at least partial sterilization of the lesion. It has been shown that enterococcic streptococci, which the organisms in this case may have been, are particularly resistant to the sulfonamides.<sup>4</sup>

The terminal picture of repeated attacks of hyperpnoea, apnea, convulsions, and coma probably resulted from reflex stimulation (Hering Breuer) of the respiratory center via the vagus nerve. Such stimulation can be produced by an aneurysmal sac, chronic pneumonitis, and pulmonary distention. This leading to increased sensitivity of the respiratory center to carbon dioxide will result in alternating periods of hyperpnoea, apnea, and finally respiratory alkalosis with attendant coma and convulsions. The demonstration of calcium deposition in the kidneys and lung framework, even though minimal, is indicative of a disturbed calcium metabolism as the result of alkalosis.<sup>7</sup> The occurrence of these findings in similar cases of cardio-pulmonary disease, without evident causes or effects of an absolute hypercalcemia, is offered as evidence that an appreciable respiratory alkalosis existed. The parathyroids, however, were not examined. Death resulted from destructive involvement of the cardiac neuromuscular tissue and attendant disturbed cardio-dynamics, complicated by chronic pneumonitis, inadequate and vicarious pulmonary gaseous exchange, and terminal respiratory alkalosis.

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Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## The Northwestern Ohio Medical Association

JONATHAN FORMAN, M.D.

(Continued from February, 1945, issue)

THE Northwestern Ohio Medical Association continued to meet regularly twice a year. This has led to some confusion as to the age of the society, some thinking that when they heard of the hundredth meeting that there had been that many annual meetings. This is an understandable mistake since meetings have been held once a year in our times.

1877

The Association met in Van Wert, Ohio, on the 22nd day of May, 1877. Dr. S. B. Hiner reported a case of post partum hemorrhage with an hour glass contraction of the uterus and partial detachment of the placenta. Dr. McConnell reported a case of post partum hemorrhage occurring one hour after delivery. After the adjournment for dinner, the society reconvened to discuss diseases and operations of the uterus. The action taken three years before in expelling Dr. W. H. Meyers was reconsidered and Dr. Meyers was reinstated.

Resolutions were adopted in regard to the death of Dr. Thomas Ballard.

One of the amusing incidents of the business meeting was the disposition of a motion that the retiring secretary be reimbursed for his traveling expenses during his term of office. The motion was lost.

The disciplining of members continued.

Dr. W. H. Meyers presented himself, after his reinstatement, with a demonstration of a small boy afflicted with Pott's curvature of the spine and demonstrated the method of applying plaster of paris bandages. Dr. J. I. Kimmel sent a communication asking to withdraw from membership. Dr. A. Hurd denied the right of the doctor to withdraw. On a motion, however, the withdrawal was accepted. A communication was received from the Toledo Medi-

### The Author

● Dr. Forman is professor of the History of Medicine at Ohio State University, Columbus.

cal Society inviting this society to meet in that city in joint session with the Southern Michigan and the Northeastern Indiana Societies on the first Tuesday of the following December.

In the Fall, the society met in Toledo under the presidency of Dr. Cuykendall. Dr. W. O. Hantz read a paper on "Criminal Abortions". Dr. C. A. Kirkley read a paper, "Ovariectomy Performed Twice on the Same Subject Successfully". Dr. Waddel made an elaborate report on the post mortem of the same case. Dr. Pooley professor of the Starling Medical College, delivered an address, "General Situations in Regard to Surgery". Next morning J. U. Curry, M.D., read a paper on "Use and Abuses of Caustics in Eye Diseases". W. T. Ridenauer reported a case of "Epiphyseal Ostitis of the Head of the Right Tibia"; A. Bigelow, M.D., "Terrestrial Magnetism as a Therapeutical Agent"; S. F. Forbes, "Observations on Colle's Fracture"; Thomas Waddel, "General Considerations Regarding the Value of Pessaries". In the afternoon a large number of the members, upon invitation, visited the St. Vincent's Hospital.

1878

The regular Summer meeting of this year was held at Findlay, Ohio, as had been planned. Dr. M. C. Cuykendall of Bucyrus occupied the President's chair and delivered his address on "Plain Talk". A popular lecture was then given by Dr. D. M. Kinsman of Columbus, Ohio, "Some of the Relations of Filth to the Production of Disease". The next morning Dr. A. Hurd read

Abstracted from the original minutes of the Northwestern Ohio Medical Association.

a paper on "Tuberculous Meningitis"; Dr. S. B. Hiner, "Acute Meningitis"; Dr. C. E. Beardsley, "Capsular Wounds of the Knee Joints"; Dr. D. H. Brinkerhoff, "Detached, Displaced and Enlarged Gall Bladder".

A new minute book was ordered purchased and the secretary was directed to transcribe the minutes from the old book onto the new book.

Dr. S. B. Hiner exhibited a post mortem specimen of cystic sarcoma of the female breast. Dr. J. W. McCracken read a paper, "Placental Previa;" Dr. W. C. Chapman, "Blood Letting" (which the secretary records as having elicited a spirited discussion); Dr. S. S. Thorn, "A Case of Retention of Urine" (the cause being traumatic). Dr. S. B. Squirers exhibited a post mortem of a remarkable calculus, giving its history. Dr. T. C. Ballard read a paper, "Quinine as an Anti-Pyretic in Typhoid-Pneumonia". Dr. F. W. Entrikin presented an ovarian cyst which he had removed successfully by himself. An important amendment was made to the constitution and legally adopted at this meeting, viz., "All members shall be assessed \$1.00 per year. If absent two years or neglecting or refusing to pay such an assessment, they may be expelled by a vote of two-thirds of the members present at any regular meeting. This penalty may not be enforced in case of sickness of a member or his family."

On November 26, 1878, we find the Northwestern Ohio Medical Association in joint session with the Union Medical Association of Northeastern Ohio.

The regular program was postponed until one o'clock and a report of cases was called for. Dr. Hamon of Warren opened the discussion, "Chloroform in Premature Labor" and this took the rest of the morning. In the afternoon Professor W. J. Scott delivered a lecture on "Impulsive Insanity"; Professor M. C. Cuykendall, "Fractures of the Long Bones"; all of that illustrated by drawings. Dr. W. C. Chapman, "Therapeutics"; Dr. R. T. Johnson, "Regeneration of Bone"; A. W. Ridenour, "Rubber Bandages". This was followed by a general discussion on the subject of diphtheria. Most of those present took part.

The next day L. S. Ebricht read a paper on "Yellow Fever"; Dr. P. H. Phillips, "A Study of Some of the Causes of Failure in the Treatment and Fracture of the Long Bones"; Dr. Joseph Sayer, "Milk Sickness"; Dr. W. S. Battles, "Alcohol"; Dr. W. O. Handy, "Resurrection of the Body."

1879

May 1, 1879, found the society in its regular semi-annual session and once again in the City Hall at Tiffin. The President, Dr. A. Brayton, was in the chair. The program followed again the pattern of the current interests. Dr. W. F. Ridenour read a "Report of a Case of Ovari-

otomy"; Dr. G. A. Collamor, "A Report on a Case of Meningeal Hemorrhage Resulting in Death" (the autopsy had revealed it to be of syphilitic origin); Dr. P. H. Brooks, "The Transmission of Disease from Father to Child Through the Spermatozoa"; Dr. A. Wangaman, "Some Evils in School Life"; Dr. M. C. Cuykendall gave a popular address that evening on "Facial Angle, Is It an Indication of the Intellectual Capacity?"

The next day Dr. F. W. Finnin read a paper on "Pelvic Hematocele with a Report of a Case"; Dr. J. Bland, "Anteversion of the Uterus"; Dr. A. S. Williams, "Some Cases of Disease of the Rectum with Specimens of Foreign Substances Ejected"; Dr. Willard, "Prophylaxis in Medicine" (ordered printed); Dr. F. W. Entrikin, "A Case of Floating Kidney".

Following these minutes we find an innovation in the records in that one full page is devoted to the memory of Thomas Waddel who had died at the age of 35. His parents had come from Ireland and his literary education had been obtained in the common schools of Canada, his medical education at the University of Buffalo and at Wooster. During his residence at Wooster University in Cleveland he was prosector to the Chair of Anatomy and the valedictorian of the class of 1871. He practiced for a while in Chardon and came to Toledo in 1873 where he lived and practiced until his death. He was on the staff of St. Vincent's, an active member of the Board of Health, lectured on gynecology in the Toledo Medical School, and was one of the editors of the *Medical and Surgical Journal*.

The Winter meeting was held this year in Lima, Ohio, again. Dr. D. H. Brinkerhoff was the President. The program again was practical. Dr. Geo. A. Collamor read a paper on "When and How Should We Deliver the Placenta?"; Dr. John H. Currie, "Sympathetic Ophthalmia"; Dr. W. C. Chapman, "Therapeutics of True Croup". In the evening a popular address was delivered by G. V. Dorsey on "Malarial Fever". Upon readjournment a discussion of croup was continued. Much attention was given to traceotomy. Then Dr. S. B. Hiner read a paper on "Specialties". Professor Dawson delivered a lecture on "Surgery", confined principally to "the Bavarian Dressing" for fractures of the long bones illustrated by clinical application and also on the merits of "Martin's Rubber Bandages". At the business meeting Dr. J. F. Shaufuer offered a resolution that the Association petition the Legislature for more stringent laws that the people and the profession might be protected. This resolution was adopted. Whereupon Dr. A. W. Small, veterinary surgeon, read a paper in which he made a plea for the veterinary profession. Professor Ramey then gave a lecture on "Dysmenorrhea".

(To be continued)



# Analysis of Burton-Hill Bill Which Authorizes Use of \$100,000,000 To Aid States in Hospital Building

A BROAD program of grants-in-aid to states to assist in the construction of hospitals and public health centers is provided for in a bill, S. 191, which has been introduced in the U.S. Senate by Senators Harold H. Burton, Ohio, and Lester Hill, Alabama.

The Burton-Hill bill, which carries the general approval of the Officials of the American Protestant and Catholic hospital associations and was drafted after conferences with representatives of the American Medical Association, authorizes the appropriation for the year ending June 30, 1946, of an amount not to exceed \$110,000,000, of which \$5,000,000 may be used for surveys and planning, \$5,000,000 for administrative details, and \$100,000,000 for construction.

Now in the hands of the Senate Committee on Education and Labor, it is assumed that the proposal will be heard by a sub-committee which has been designated to consider proposed health legislation, headed by Senator Claude Pepper, Florida, and of which Senator Robert A. Taft, Ohio, is a member.

## PURPOSES OF S. 191

The declared purposes of the pending bill are twofold: (1) to assist the several states to inventory their existing hospitals, as that term is defined in the bill, to survey the need for new construction and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all people; and (2) to construct public and other nonprofit hospitals in accordance with such programs.

## DEFINITION OF TERM "HOSPITALS"

The term "hospital" is broadly defined to include "public health centers and general, tuberculosis, mental, chronic disease and other types of hospitals and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals". The definition, however, excludes any hospital furnishing primarily domiciliary care.

## CREATION OF FEDERAL ADVISORY COUNCIL

To assist in administering the provisions of the bill on a federal level, a Federal Advisory Council is proposed. The Surgeon General of the Public Health Service will serve as chairman ex-officio of the council, and the other eight mem-

bers will be appointed by the administrator of the Federal Security Agency. The appointed members will be persons "who are outstanding in fields pertaining to hospital and health activities, and a majority of them shall be authorities in matters relating to the operation of hospitals".

The Council must meet at least once a year but may meet more frequently if the Surgeon General deems it necessary. On the request of three or more members, it is made mandatory that the Surgeon General call a meeting.

## STATE ADVISORY COUNCILS

Applications that will be submitted to the Surgeon General for approval, proposing surveys of existing facilities and the development of programs for construction, must provide for the designation of state advisory councils to include representatives of "nongovernment organizations or groups, and of state agencies, concerned with the operation, construction or utilization of hospitals, to consult with the state agency in carrying out such purposes".

## FEDERAL APPROPRIATIONS

For the fiscal year ending June 30, 1946, total appropriations of \$110,000,000 are proposed. Of this amount \$5,000,000 will be allotted to the several states for surveys and planning, \$5,000,000 to cover administrative expenses in carrying out plans that have been approved, and \$100,000,000 for the construction of hospitals and related facilities. Thereafter such sums for construction and administrative purposes will be authorized for each fiscal year as Congress may determine to be necessary.

## ALLOTMENTS TO STATES

The sum to be made available for surveys and the development of programs will be allotted by the Surgeon General to the several states on the basis of their respective populations, financial needs and such other factors as he finds relevant. In connection with these allotments no specific provision appears in the bill for advice from the Federal Advisory Council. From these allotments each state will be entitled to receive, after an application has been approved, an amount equal to the "federal percentage", which will be determined in accordance with regulations made by the Surgeon General. "Such percentage shall be not less than 25 per centum or more than 75 per centum [presumably of the estimated cost of the survey and the development of the pro-

gram] for any state, and within that range such percentage shall be determined for the several states on the basis of their relative financial needs."

The sum to be made available for construction and for administrative expenses will be allotted on the basis of the population and financial needs of the respective states and, in the case of allotments for construction of hospitals, the relative need for such construction, or, in the case of allotments for administrative expenses, on the basis of special administrative problems.

The Surgeon General will be authorized to promulgate regulations under which these grants are to be made, but only on the recommendation of the Federal Advisory Council and after consultation with the state agencies designated in the several state plans.

Grants to a particular state may be terminated whenever the Surgeon General finds, after affording reasonable notice and opportunity for a hearing, that there has been a failure substantially to comply either with any provision required to be included in the application for funds for surveys and the development of programs or in any construction plan, or with any regulation promulgated by the Surgeon General.

#### APPROVAL OF STATE APPLICATIONS AND PLANS

In order to obtain any of the federal money made available for surveys and for the development of construction programs, a state must make an application therefor to the Surgeon General. The application must (1) designate a single state agency as the sole agency to supervise the survey and to develop the program; (2) provide for the designation of a state advisory council to include representatives of non-governmental organizations or groups and of state agencies concerned with the operation, construction or utilization of hospitals; (3) provide for compliance with standards prescribed by the Surgeon General with the approval of the Federal Advisory Council, and (4) provide that the state agency will make such reports, in such form and containing such information as the Surgeon General may from time to time require and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports. If an application complies with the foregoing requirements, the bill requires the Surgeon General to approve it.

Before a state may participate in any benefit from the distribution of federal money made available for construction programs and for administrative expenses, it must submit a state plan to the Surgeon General for approval. A state plan, to be approved, must (1) designate a single state agency as the sole agency for the administration of the plan, or designate such

agency as the sole agency for supervising the administration of the plan; (2) contain satisfactory evidence that the state agency designated will have authority to carry out such plan; (3) set forth a hospital construction program which the Surgeon General, on recommendation of the Federal Advisory Council, finds to be in accordance with standards prescribed by him with the approval of the Council, and to be sufficient, in conjunction with existing facilities, to provide the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all the people of the state, and which, in the case of a state which has developed a construction program after making the required surveys, conforms to the program so developed; (4) set forth the relative need, determined in accordance with standards prescribed by the Surgeon General with the approval of the Federal Advisory Council, for the several projects included in the program, and provide for construction, so far as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need; (5) provide such method of administration as the Surgeon General finds necessary for the proper and efficient operation of the plan, including provision for affording to an applicant for a construction project an opportunity for hearing before the state agency; (6) provide that the state agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time require, and comply with such provisions as the Surgeon General may from time to time find necessary to assure the correctness and verification of reports, and (7) provide that the state agency will from time to time review its hospital construction program and submit to the Surgeon General and to the Federal Advisory Council any necessary modifications. If a state plan meets these requirements, it must be approved by the Surgeon General.

#### APPROVAL OF PROJECTS AND PAYMENTS FOR CONSTRUCTION

For each construction project contained in a state plan there must be submitted to the Surgeon General an application by a state or political subdivision or by a public or other non-profit agency. Each application must set forth a description of the site for such project, detailed plans and specifications, reasonable assurance that the title to the site is or will be vested solely in the applicant and reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed.

No application for a project may be approved by the Surgeon General unless its approval has been recommended by the state agency. The bill does not specifically require the Surgeon Gen-



eral to seek the advice of the Federal Advisory Council in passing on applications for projects.

If an application for a project is approved, the Surgeon General will certify to the Secretary of the Treasury an amount equal to the "federal percentage" of the estimated cost of the construction of the project, designate the appropriation from which it is to be paid and from time to time certify instalments to be paid on account.

In determining whether to approve a project, in determining whether to certify an instalment and in any inspection authorized by the bill, the Surgeon General will as far as practicable utilize the services and advice of the Federal Works Agency in reviewing the title, working drawings and specifications of any project, supervising the awarding of contracts and inspecting the performance of the work.

#### CONFERENCES OF STATE AGENCIES

The Surgeon General will be authorized, in carrying out the provisions of the bill, to invite representatives of as many state agencies to confer with him as he deems necessary or proper. A conference of the representatives of all state agencies, however, must be called annually by the Surgeon General. If five or more of such agencies request it, the Surgeon General must call a conference of representatives of all state agencies joining in the request.

#### PROMULGATION OF REGULATIONS

The Surgeon General is authorized to make such regulations and perform such other functions as he finds necessary to carry out the provisions of the bill. All regulations with respect to grants to states for administrative purposes in carrying out plans or for construction projects, however, may be promulgated only on recommendation of the Federal Advisory Council, as before noted, and after consultation with state agencies. The bill provides that, as far as practicable, the Surgeon General shall obtain the agreement of state agencies prior to the promulgation of any such regulations or amendments.

#### MISCELLANEOUS

A "public health center" within the meaning of this bill means a publicly owned facility for the provision of public health services and medical care, including related facilities such as laboratories, clinics and administrative offices operated in connection with public health centers. A "nonprofit hospital" is defined to mean any hospital owned and operated by a corporation or association, no part of the net earnings of which inures to the benefit of any private shareholder or individual. The money that is allotted to a state for construction purposes may

not be expended for the cost of the acquisition of land, except in connection with the construction of public health centers.

#### OTHER FEDERAL BILLS OF INTEREST

Following are some of the more important medical and health proposals among scores which have been introduced in the present U.S. Congress, with brief comments on each:

**H.R. 1442**, proposes an amendment to the Social Security Act by which Federal assistance would be made available to the states to permit them to provide medical, surgical and hospital care to recipients of old age assistance through purchase of insurance or through a plan administered by a state agency.

**H.R. 284**, to provide medical facilities for all Federal employees. There is already established some facility of this kind for certain departments, but the bill would extend coverage to all Federal employees. The services are to be established only upon recommendation by the Civil Service Commission after consulting with the Public Health Service and are to be limited to: (1) Treatments of minor illnesses and dental conditions, except in cases of emergency; (2) Pre-employment and other examinations; (3) Referral of employees to private physicians and dentists; (4) Education and preventive programs relating to health, including alleviating of health hazards in the working environment.

**H.R. 395**. Same as the old Wagner-Murray-Dingell Bill, S. 1161, which died with the last Congress.

**H.R. 491**, an anti-vivisection bill to apply only in the District of Columbia but the proponents of this bill consider that if Congress enacts it for the District of Columbia they will have thereby gained a great point in having a similar law enacted in the various states.

**H.R. 519**, to provide for a National Board of Water Pollution Control. Mr. Mundt feels that many streams are unnecessarily polluted. In many instances the pollution is a health hazard.

**H.R. 525**, to provide for the authorization of the Department of Labor "to cooperate with State agencies administering labor laws in establishing and maintaining safe and proper working conditions in industry and in the preparation, promulgation and enforcement of regulations to control industrial health hazards". A sum of \$5,000,000 is asked to finance the work.

**H.R. 610**, to provide for defining the term "physician" in the U.S. Employees' Compensation Act to include chiropractic practitioners; only in those states where chiropractors have been licensed. Further provides that chiropractic prac-

tioners should have hospital facilities such as those enjoyed by physicians and osteopaths.

**H.R. 713**, to provide for the creation of one medical academy in each corps area in the United States, each to enroll a minimum of 295 students to be selected as follows: Each Representative and Senator from the area shall designate 5 principals and 10 alternates, any vacancies shall be filled by the Commanding General of the Army Corps; candidates shall be at least 20 and not over 25 years of age, shall be graduates of a college or a university or possess the qualifications for entrance into a medical school in the State in which they reside, must be citizens of

the United States and of good moral character. Upon satisfactory completion of the course of study the candidates shall be commissioned in the Army, or in the Navy, or in the Public Health Service; they must continue in such service for at least ten years, unless it shall be certified that there is no further need for their services.

**H.R. 1284**, to provide that every woman now registered in a nurse training school shall be subject to registration and selection for induction into land or naval forces upon her graduation.

**H.R. 139**. This bill is the same as H.R. 612, which expired with the last Congress.

## Last Call for 1945 Membership Dues! Only Members Can Be Sent Future Issues of The Journal

**This, the March issue of The Journal, will be the last issue which will be received by those who have not paid their 1945 Ohio State Medical Association dues, excepting THOSE IN MILITARY SERVICE WHO ARE ON THE MEMBERSHIP ROSTER THROUGH WAIVER OF DUES.**

**This action is necessitated to comply with the Postal Regulations and the Constitution and By-Laws of the Ohio State Medical Association.**

**To be sure of receiving future issues of The Journal, those who have not as yet paid their 1945 State Association dues should GET IN TOUCH IMMEDIATELY WITH THE SECRETARY-TREASURER OF THEIR COUNTY MEDICAL SOCIETY WHO IS RESPONSIBLE FOR FORWARDING DUES TO THE STATE ASSOCIATION OFFICE AT COLUMBUS.**

**As soon as membership dues are received at the Columbus office, the member's name is restored to the membership roster and The Journal's mailing list.**

**If you have not done so, PAY YOUR 1945 MEMBERSHIP DUES IMMEDIATELY TO YOUR LOCAL SECRETARY-TREASURER as this is the only way you can keep your State Association membership in good standing and receive future issues of The Journal.**

**Cincinnati**—Care of the sick must be kept free from political domination, Dr. L. Howard Schriver, President of the Ohio State Medical Association, told the Presbyterian Men of Greater Cincinnati at a recent meeting. Dr. Schriver also addressed the Lions Club on "Socialized Medicine".

**Toledo**—The name of Women's and Children's Hospital has been changed to Riverside Hospital.

**Columbus**—Dr. Carl A. Wilzbach, Cincinnati health commissioner, was guest speaker at the annual meeting of the Council of Social Agencies. His subject was: "The Framework of a Social Hygiene Program".

**Ironton**—Dr. V. V. Smith gave a talk on the progress made in the field of medicine during the last five years, at a meeting of the Lions Club.

**Fremont**—New staff officers of Memorial Hospital are: Dr. C. I. Kuntz, Fremont, chief of staff; Dr. E. A. Baker, Clyde, vice-president; Dr. Robert Fox, Green Springs, secretary; and Dr. A. F. Schultz, retiring chief, Dr. J. L. Curtin and Dr. J. C. Boyce, members of the executive committee, all of Fremont.

**Athens**—In a talk to local Kiwanians, Dr. H. T. Phillips, health commissioner of Athens County, said that conservation of health is the most important part of the conservation program.

**Cleveland**—A \$500,000 nurses' home to house 300 will be built by St. Luke's Hospital as a post-war project.

**Ravenna**—New staff officers of Robinson Memorial Hospital are: Dr. J. S. Deyell, chief, and Dr. Myron S. Owen, secretary.



# Medical and Health Services in a Small Industrial Plant

MAYNARD C. KISER, M.D., TIPP CITY, OHIO

A MEDICAL department was deemed necessary at the Kilgore Manufacturing Company plant at Tipp City shortly after the onset of the present war when the company's personnel increased from approximately 100 to between 700 and 800.

Our present program was devised with three main ideas in mind: First, to give employees the benefit of emergency first aid for injuries and minor ailments; second, to decrease as much as possible, lost man-hours due to injuries and minor illnesses by both emergency first aid and proper placement of handicapped workers; third, to provide a means for cooperation with physicians in private practice of medicine rendering medical care to the plant's employees.

## FACILITIES AND SUPPLIES

At present our working facilities consist of two rooms equipped with supplies for performing physical examinations, for treating minor injuries, for giving first aid for minor illnesses and for keeping records.

The supplies consist of various antiseptics, dressings and instruments for small suture cases, burn ointments, etc. Very few drugs are dispensed. Those dispensed consist of the ones used in emergencies, since the only treatment given in illnesses at the plant is that which will offer the employee some immediate relief until he can consult his family physician. Obviously, this results in a mutual advantage to the employee and to the plant, providing the former with emergency care and reducing lost man-hours for the company.

## DUTIES OF NURSE

A nurse is on duty eight hours daily—six hours during the first shift and two hours during the second. The reason for this arrangement is that there is not enough work on the second shift to warrant the employment of two full-time nurses. The nurse's duties consist of taking histories on all new employees, giving first aid in all injuries and illnesses occurring in the plant, and keeping records.

When a new employee is hired, he is seen by the nurse before going into the plant. She takes a history as to previous illnesses, operations, injuries and present state of health. In addition, she checks the temperature, pulse, weight and eyes.

If there is no obvious disability and no question about the employee being physically able to work, he is permitted to go into the plant. His record is kept in the incomplete file and his physical examination is completed by the plant

**EDITOR'S NOTE:** The accompanying article, written by Dr. Kiser on request, offers helpful information and suggestions for physicians who are directing medical and health services in moderate-sized industries. It outlines the program being carried on at the Kilgore Manufacturing Company's plant at Tipp City, Ohio, under the direction of Dr. Kiser. Many phases of the setup there are adaptable to programs now being carried on, or contemplated, in factories of similar size in communities of comparable population—approximately 3,000.

physician during the next 24 to 48 hours.

If there is any question concerning disabilities and the placement of new employees, it is the responsibility of the nurse to consult the plant physician at once so the physical examination can be completed by him before the employee begins work.

## FILES AND RECORDS

Completed records on all employees are kept in a permanent file. On the reverse side of the record, notations are kept concerning an employee's visits to the first-aid station whether for injuries or illnesses, i.e., as to what was the employee's complaint at the time of visit, what treatment was given and whether the employee was seen by the nurse or the plant physician.

The nurse is instructed that all injuries received in the plant are covered by the Ohio Workmen's Compensation Law and that any employee has the privilege of selecting his own physician. If an employee requests that his own physician be called, the nurse calls such physician, as under the company's policy an employee's physician is welcome to use the first-aid facilities of the plant.

## ORDERS ISSUED NURSE

When an injured or sick employee is brought into the first-aid station, it is the nurse's responsibility to determine whether or not a physician should be called and if there is any doubt, her instructions are to call one. A complete printed list of standing orders of the plant physician is displayed inside the supply cabinet as reference for the nurse in rendering first aid. She is instructed to give the employee only absolutely necessary advice and to refer the employee directly to his family physician for all illnesses.

## CHECK OF RETURNING EMPLOYEE

When an employee has been absent from work for more than 48 consecutive hours because of

illness, he is called to the first-aid station by the nurse upon his return to the plant. The nurse is directed to find out whether or not the employee has been under a physician's care and if he appears to be physically able to work. No employee may return to work if he has an elevation in temperature. A questionable case must present a statement from the attending physician that the employee is physically able to work. It should be noted that a physician, who states that a person who has been ill recently is able to resume work, accepts a real responsibility, thus it should be very definite in the physician's mind that this is true.

#### CLERICAL WORK

As stated, the nurse keeps the records of the physical examinations of new employees and visits to the first-aid station. Also, she fills out all forms required by the Ohio Industrial Commission, forwards them to the attending physicians and when they are returned, makes a duplicate copy for the employee's file, transmitting the original to the Commission.

#### DUTIES OF PLANT DOCTOR

The plant physician spends a certain amount of time at the plant each day. His duties consist of making physical examinations on all new employees, directing the medical treatments given in the plant and cooperating with the safety committee of the plant in minimizing or eliminating health hazards in the plant.

A routine physical examination is done on all employees. If any abnormalities are discovered, the employee is questioned as to whether he is aware of the abnormality and whether he is under a physician's care. When any condition is found that is of sufficient importance to warrant placing the employee on a job which will not aggravate the condition, the personnel department is advised as to where, from the standpoint of health, it will be safest for the employee and where he can work most efficiently. There are few instances in these days that a new employee is rejected completely because of a physical defect.

It is the plant physician's duty to supervise the work of the nurse to see that employees are receiving proper care. He is responsible for reporting health hazards to the plant safety committee. In the event one type of injury becomes prevalent or an occupational disease occurs too frequently, he is expected to ascertain, if possible, what can be done to correct the offending agent.

#### COOPERATION WITH OTHER PHYSICIANS

Personal experience has shown that a plant physician will receive much better cooperation from other physicians in the community if he will

discuss the conditions and problems of his plant with them. As a means of securing this kind of cooperation, the Kilgore Manufacturing Company has followed the policy of periodically inviting members of the county medical society to meet at the plant as guests of the management. On such occasions, discussions are held on various health hazards at the plant, prevailing occupational diseases and the policies of the company concerning treatment of injuries, emergency illnesses, etc.

#### COOPERATION FROM MANAGEMENT

Naturally, it is much easier for a physician to direct a medical department in an industrial plant if he receives cooperation from the executives of the organization, meaning that he is allowed a fairly free hand in carrying on medical and health services and is not subjected to dictation on matters affecting his department. Such cooperation exists to a splendid degree between the executives and the medical department of the Kilgore Manufacturing Company.

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### New Plan in Handling Medical Only Claims May Benefit Physicians

In an effort to expedite the disposition of C-3 (Medical Only) Workmen's Compensation claims, a new service has been inaugurated by George H. Thompson, supervisor of claims, State Industrial Commission.

Upon receipt of a C-3 blank, the Claims Section will mail a postal card to the claimant's employer showing the claim number assigned, date of injury, and the claimant's name as it appears on the blank. The Industrial Commission is requesting the employer to furnish this claim number to the claimant, attending physician, hospital, or any person who may be involved in the case. The cards are being mailed for all C-3 claims filed on and after January 26, 1945.

A physician who wishes to write to the Industrial Commission about a claim should first ascertain its number from the employer. Designation of the claim by number will greatly facilitate the proper handling of such an inquiry by the Commission.

The new system should also enable a physician to determine whether an employer has neglected to file a C-3 application. When a reasonable time has elapsed after a physician completes treatment in a medical-only case and forwards the completed C-3 to the employer, and the employer is unable to furnish the number of claim, the physician may assume that the employer has failed to forward the executed blank to the State Industrial Commission.



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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

# Bills To Improve Ohio's Mental Health Program, In Line With Committee's Recommendations, Are Introduced

A SERIES of bills, based on recommendations of Former Governor Bricker's Committee on the Mental Health Program for Ohio, (see December, 1944, issue of *The Journal*) is pending in the present Ohio General Assembly, laying the groundwork, if enacted, for great advances in the state's care of the mentally ill and defective. These measures are:

**Senate Bill 3**, to establish a building commission and to appropriate \$25,000,000 for enlarging present state hospitals for the mentally ill or mentally defective, or building new ones.

**Senate Bill 48**, to change the name of the Division of Mental Diseases to the "Division of Mental Hygiene"; change the title of the commissioner to "Commissioner of Mental Hygiene"; change the name of the Bureau of Mental Hygiene to "Bureau of Prevention and Education"; place the Bureau of Juvenile Research in the Division of Mental Hygiene; establish a Bureau of Examination and Classification in the Division of Correction.

**Senate Bill 49**, to eliminate the names of individual state institutions and give the State Welfare Department not only control over them but to provide them, or new institutions, with appropriate names.

**Senate Bill 65**, to provide state aid to schools for maintaining special classes for mentally retarded children.

**Senate Bill 75**, to provide for the admission of minors to institutions for epileptics for observation and to authorize care of mentally ill, epileptic, and mentally deficient elsewhere than in institutions.

**Senate Bill 77**, to facilitate inquiry into sanity of persons accused of crime, clarifies court procedure, and permits juvenile court also to commit persons pleading insanity, to a local, state or receiving hospital for observation.

**Senate Bill 78**, to include drug addiction and excessive use of sedatives or stimulants as grounds for commitment to a hospital for the mentally ill; to define "mentally deficient" and to establish central registration of those adjudged mentally deficient.

**Senate Bill 87**, to require the State Welfare Department to provide and designate special institutions for the custody, care and treatment of mentally deficient offenders, of the criminal insane, and of psychopathic offenders, and to provide for commitment, transfer and discharge to and from such institutions.

## TALLMAN ENDORSES PROGRAM

Dr. Frank F. Tallman, State Commissioner of Mental Diseases, regards the recommendations

of the Governor's Committee on Mental Health as a "well-rounded program which if placed into operation would put Ohio among the forerunners of all states in caring for mental patients".

Pointing out that he is in complete agreement with the report which not only urged new facilities to provide for mentally-handicapped persons but also advocated extensive preventive measures, Dr. Tallman said:

"The report might well be used as a working blueprint and its subject matter adopted as a guide to the development and expansion of adequate facilities in providing the people of the state with a constructive, well-balanced mental hygiene program."

## ALL FACTORS CONSIDERED

The committee advocated a 10-year program which would more than double the present bed capacity in state institutions and recommended appropriation of funds for the next two years which would provide for 18,250 additional beds to meet immediate needs.

"One cannot help but be impressed with what might be termed the well-balanced program that has been recommended in which emphasis has been placed on all important factors including institutional facilities, personnel, extramural care, early treatment and prevention", Dr. Tallman said.

"We must have institutional facilities which will allow quick and efficient treatment and care of the mentally ill, the mentally defectives, and the epileptics since with the passing of each day that a patient has to wait for treatment or training, the ultimate outcome becomes less hopeful", he said.

## SHOULD BEGIN NOW

"It should be remembered that while a building program can not bear immediate fruit and will be difficult to construct with full effect during wartime, a beginning can and should be made", the Commissioner added.

In view of wartime restrictions which might limit new construction, Dr. Tallman emphasized that it was essential for the state to take full advantage of several existing properties which the State Welfare Department recently leased and which the Governor's Committee urged be developed.

Two of these were a municipal hospital at Youngstown which was leased as a receiving hospital for the area now covered by the Massillon State Hospital; and the other an institution at Tiffin to be used for the early treatment and education of epileptics which would also house an



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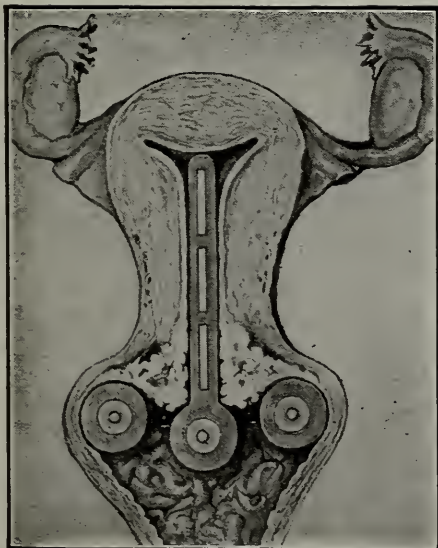
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#### TIFFIN SITE TAKEN OVER

The welfare department has officially taken over the property at Tiffin which formerly housed the Orphans Home of the Junior Order of United American Mechanics. It was acquired on an annual lease basis with option to purchase at \$750,000 and will be known as the Tiffin State Institute. The site consists of 644 acres with 53 buildings. It is planned to provide facilities for between 700 and 800 epileptic patients with room for an additional 200 patients should a remodeling program be undertaken.

Patients at the institution will include some who will be transferred from the Ohio Hospital for Epileptics at Gallipolis but the majority will be new court commitments.

#### MUST HAVE ADEQUATE STAFF

Dr. Tallman believes that while new buildings are essential in the new state program, "an adequate staff of good quality and well trained to do the various jobs, is the keystone of any institutional program".

"The object of any hospital or institution should be to avoid as completely as is consistent with good treatment, a slow or almost static turnover of bed use and to do this requires a high type of personnel and also means that the most modern methods of treatment and custody should appropriately be used", he said, adding:

"Our present serious personnel difficulties are in part due to the fact that we have always had too few employes, the situation being considerably aggravated by wartime conditions. Adjustment of salaries and living conditions for employes, as the Governor's Committee so strongly urged, would be a step forward in competing with other states and attracting to our service desirable people."

#### EXTRAMURAL CARE NEEDED

As part of a strong state-wide mental health program, the Commissioner pointed out that serious consideration should be given to extramural care, providing for proper placement and care of persons who have been hospitalized. Such a program demands well-organized social service departments in institutions staffed with persons proficient in this particular work, he observed.

Dr. Tallman also pointed out that in the past too little emphasis has been placed on the preventive aspect of mental hygiene and commended the Committee's recognition of the value of such work.

As a first step in building up the preventive and educational program, the department has secured Dr. Edward J. Humphreys, formerly of the Michigan State Hospital Commission, to direct the present Division of Mental Hygiene which will be renamed the Bureau of Prevention

and Education if pending legislation is enacted.

"As a part of the Committee's report dealing with preventive mental hygiene, the recognition of the importance of residential clinics for both children and adults is to be heartily applauded", Dr. Tallman said. "Clinics of this type staffed with a psychiatrist, a psychologist, and a psychiatric social worker are recognized throughout the nation as a standard. They are involved not only in treating children and adults but as springboards for educational programs in the community in which they exist with reference to schools, courts, and social agencies."

#### SOME PLANS COMPLETED

The Commissioner also gave strong endorsement to the recommendation for establishment of a special institution for mentally defective offenders and psychopathic criminals.

Since the Committee's report was issued, the department has announced that plans have been completed for the construction of new facilities at Apple Creek and the Ohio State Sanatorium at Mt. Vernon, involving estimated expenditures of more than \$2,000,000 and making more than 1,500 additional beds available.

At Apple Creek the plans call for the construction of three new cottages and a new administration building, making room for 1,000 additional patients. At Mt. Vernon, where about 106 tubercular patients are now housed, the plans call for the construction of two buildings which would provide facilities for around 550 tubercular insane patients now confined in state hospitals.

#### ASSISTANT COMMISSIONER NAMED

On February 17, State Welfare Director Reams announced the appointment of Dr. Attilio Laguardia as Assistant Commissioner of Mental Diseases. Among Dr. Laguardia's responsibilities will be the supervision of the medical and psychiatric programs in the institutions of the Division of Mental Diseases. He will also assist Commissioner Tallman with administration.

Dr. Laguardia is a graduate of the College of Physicians and Surgeons, Columbia University. He is a diplomate of the American Board of Psychiatry and Neurology and has had an extensive postgraduate training in psychiatry. Dr. Laguardia began his professional career at the Psychopathic Division of Bellevue Hospital, then joined the staff of the Rockland State Hospital, a large 7000-bed institution of the Department of Mental Hygiene in New York, where until his appointment here he was assistant director of the institution. Dr. Laguardia brings to his new position a wide experience of institutional operation and therapy. He is especially interested in receiving hospitals and his experience at Bellevue will be valuable in setting up the contemplated system of receiving hospitals in this State.





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**The boy's are not.**

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---

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# Reorganization of Faculty of College of Medicine at Ohio State University Announced by New Dean

THE BOARD of Trustees of Ohio State University has approved a number of major changes in the faculty of the College of Medicine in accordance with recommendations of the new dean, Dr. Charles A. Doan.

The former dean of the College of Medicine, Lt. Col. A. Hardy Kemp, M.C., was named to the professorship of public health and hygiene, effective pending his release from active duty in the Army.

Dr. R. C. Baker, former chairman of the Department of Anatomy and for the past two years acting dean of the College of Medicine, was made permanent secretary of the medical faculty. He will devote approximately one-half of his time to administrative duties in the Office of the Dean and the remainder of his time to instruction and investigation in the Department of Anatomy.

The newly created office of junior dean will be held by Dr. George H. Ruggy. Dr. Ruggy is assistant professor in the Department of Physiological Chemistry and Pharmacology and in the Department of Medicine. He received the degree of doctor of philosophy from the Ohio State University in 1936, and in 1940 he completed the requirements for the degree of doctor of medicine at the University of Chicago. Dr. Ruggy will divide his time about equally between the administrative duties of the new office and teaching in the departments with which he is now associated.

## NEW HEAD OF MEDICAL DEPARTMENT

The guidance of the Department of Medicine is now in the hands of the new chairman, Dr. Bruce K. Wiseman. Dr. Wiseman is formulating plans that will make possible the introduction of new and expanded contacts in the clinical instruction of the junior and senior students.

Dr. Henry Wilson, Jr., associate professor of medicine, was appointed assistant medical director of the University Hospital and assistant chief of staff. He will work with the superintendent in an advisory capacity with reference to administrative problems in the hospital involving the practice of medicine.

Mr. Louis B. Blair, who has served as assistant director of the University Hospital, has been promoted to superintendent, with the academic rank of assistant professor of hospital administration.

Dr. C. Joseph DeLor, assistant professor of medicine, is the new assistant medical director of the Out-Patient Dispensary. Aside from his

teaching duties he will be responsible for organizing and correlating the teaching in the senior year in this area.

## ADD ASSOCIATE IN PEDIATRICS

Dr. Warren Wheeler has accepted the position of associate professor of pediatrics. Dr. Wheeler is a graduate of Harvard Medical School, having received his resident training in pediatrics at the Boston Children's Hospital. At present he is on the staff of the Department of Pediatrics, Wayne University, and director of laboratories, the Detroit Children's Hospital. In his new position he will devote full time to teaching and research, chiefly at Children's Hospital.

Dr. Jonathan Forman, lecturer in medicine, has been named professor of medical history. In his new position Dr. Forman will be responsible for the teaching of the history of medicine and for the supervision of the medical archives of the State of Ohio for the Medical Library.

## DR. TALLMAN JOINS FACULTY

Dr. Frank F. Tallman, Ohio Commissioner of Mental Diseases, has been added to the staff in neuropsychiatry as an assistant professor, and will correlate our teaching and research program at the University with his state-wide program for the better care and treatment of the mentally ill.

Dr. Doan has announced his policy of administration to include active participation in both teaching and research for all executive officers of the College of Medicine, including the dean.

A postwar planning committee has been working for many months on specific plans for expanding the undergraduate and graduate teaching and research facilities of the College of Medicine and University Hospital. If these can be realized, an important contribution to the general level of medical service and to the health interests in the entire state may confidently be anticipated, according to Dr. Doan.

## Toomey Gets Fund for Research

A gift of \$50,000 to Western Reserve University from the "associates" of Jack & Heintz, Inc., Cleveland, to enable Dr. John A. Toomey to carry on a five-year program of research into infantile paralysis, whooping cough, measles and other contagious diseases was recently announced by President Winfred G. Leutner of the university.



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# Military Roster Increased; Promotions Won by Ohio Medical Officers Listed; Breakdown by Counties

**T**HIRTEEN names were added to the Military Roster of the Ohio State Medical Association during the past month. The star (\*) in front of the names on the list indicates the man has been in service for some time but his name has just been reported to *The Journal*. Total number of names on the roster is 3,112, consisting of 2,595 in Army, 443 in Navy, and 74 in miscellaneous government services. Those whose names were added to the roster, those who received promotions and the breakdown by counties, follow:

## NAMES ADDED TO MILITARY ROSTER

| Name                     | City            | Rank                           |
|--------------------------|-----------------|--------------------------------|
| *Ahlering, Wm. C.        | Cincinnati..... | Lt. (j.g.), U.S.N.             |
| *Beluk, Stephen Richard  | Dayton.....     | 1st Lt., U.S.A.                |
| *Carpenter, E. B.        | Cincinnati..... | 1st Lt., U.S.A.                |
| *Danstrom, John R.       | Cleveland.....  | 1st Lt., U.S.A.                |
| *Konas, Clayton R.       | Cleveland.....  | Lt., U.S.N.                    |
| *Main, Robert E.         | Cincinnati..... | Lt. (j.g.), U.S.N.             |
| Novello, Salvatore       | Lima..          | Passed Asst. Surg., U.S.P.H.S. |
| *Sage, Harry Morton, Jr. | Columbus....    | Lt. (j.g.), U.S.N.             |
| *Smith, Richard N.       | Columbus.....   | Lt. (j.g.), U.S.N.             |
| *Speelman, Merrill E.    | Columbus.....   | Lt. (j.g.), U.S.N.             |
| *Sprague, Edward A.      | Athens.....     | Lt. (j.g.), U.S.N.             |
| *Stevens, Charles L.     | Columbus.....   | 1st Lt., U.S.A.                |
| *Swanbeck, Carl R.       | Willoughby..... | Lt. (j.g.), U.S.N.             |

## WIN PROMOTIONS

| Name                  | City                    | Rank                |
|-----------------------|-------------------------|---------------------|
| Bane, Russell C.      | Chillicothe.....        | Major, U.S.A.       |
| Bobey, Milton E.      | Cleveland.....          | Capt., U.S.A.       |
| Polotin, Jos. H.      | Warren.....             | Capt., U.S.A.       |
| Borreson, Albert      | Greenfield.....         | Major, U.S.A.       |
| Bremen, Harry         | Dayton.....             | Major, U.S.A.       |
| Cooper, Jack R.       | Columbus.....           | Capt., U.S.A.       |
| Craw, Bernard K.      | Toledo.....             | Major, U.S.A.       |
| Dewald, Donald W.     | Cleveland.....          | Capt., U.S.A.       |
| Dickey, Lincoln C.    | Shaker Heights.....     | Capt., U.S.A.       |
| Fidelholtz, J. N.     | Toledo.....             | Capt., U.S.A.       |
| Flynn, Wm. J.         | Cleveland.....          | Capt., U.S.A.       |
| Friedmar, Sam         | Toledo.....             | Major, U.S.A.       |
| Funk, John A.         | Coshocton.....          | Lt., U.S.N.         |
| Gerlinger, Theo. V.   | Willard.....            | Major, U.S.A.       |
| Goldcamp, John S.     | Youngstown.....         | Major, U.S.A.       |
| Jones, James F.       | Cleveland.....          | Major, U.S.A.       |
| Larson, Andrew J.     | Canton.....             | Capt., U.S.A.       |
| Keiser, Harold L.     | Fremont.....            | Capt., U.S.A.       |
| Kelly, Donald A.      | Cleveland.....          | Major, U.S.A.       |
| Knierim, H. G.        | Mansfield.....          | Lt., U.S.N.         |
| Leigh, A. M.          | Cleveland.....          | Capt., U.S.A.       |
| Lemert, Charles C.    | Cincinnati.....         | Capt., U.S.A.       |
| Lovbury, Wm. F.       | Columbus.....           | Lt. Col., U.S.A.    |
| Lyle, Herbert P.      | Norwood.....            | Comdr., U.S.N.      |
| Mannhardt, Herman W.  | Bowling Green.....      | Lt., U.S.N.         |
| Markay, O. B.         | Cleveland.....          | Lt. Col., U.S.A.    |
| McGuire, P. J.        | Barberton.....          | Major, U.S.A.       |
| McGross, N. C.        | Toledo.....             | Lt., U.S.N.         |
| Orr, Paul F.          | Toledo.....             | Surgeon, U.S.P.H.S. |
| Parker, Watson D.     | Sandusky.....           | Capt., U.S.A.       |
| Pillersdorf, Louis    | Cleveland.....          | Lt. Col., U.S.A.    |
| Roach, Wm. L.         | North College Hill..... | Major, U.S.A.       |
| Sharp, Wm. T.         | Chillicothe.....        | Major, U.S.A.       |
| Shilling, Ralph H.    | Columbus.....           | Lt. Col., U.S.A.    |
| Shively, Russell L.   | Toledo.....             | Major, U.S.A.       |
| Stevenson, Jean M.    | Cincinnati.....         | Lt. Col., U.S.A.    |
| Strauss, Victor M. B. | Cincinnati.....         | Major, U.S.A.       |
| Tapper, Ralph W.      | Dayton.....             | Capt., U.S.A.       |
| Wenzinger, Harold J.  | Defiance.....           | Capt., U.S.A.       |
| Werle, Jacob M.       | Cleveland.....          | Capt., U.S.A.       |
| Willis, W. H.         | Painesville.....        | Lt. Col., U.S.A.    |

## TABULATION BY COUNTIES

|                  |     |                  |     |                  |      |
|------------------|-----|------------------|-----|------------------|------|
| Adams .....      | 2   | Guernsey ....    | 7   | Muskingum ..     | 9    |
| Allen .....      | 39  | Hamilton ....    | 509 | Noble .....      | 1    |
| Ashland .....    | 12  | Hancock .....    | 12  | Ottawa .....     | 9    |
| Ashtabula .....  | 18  | Hardin .....     | 7   | Paulding .....   | 2    |
| Athens .....     | 11  | Harrison .....   | 4   | Perry .....      | 4    |
| Auglaize .....   | 6   | Henry .....      | 3   | Pickaway .....   | 5    |
| Belmont .....    | 14  | Highland .....   | 7   | Pike .....       | 2    |
| Brown .....      | 3   | Hocking .....    | 4   | Portage .....    | 3    |
| Butler .....     | 30  | Holmes .....     | 2   | Freble .....     | 7    |
| Carroll .....    | 2   | Huron .....      | 17  | Putnam .....     | 6    |
| Champaign .....  | 9   | Jackson .....    | 1   | Richland .....   | 38   |
| Clark .....      | 37  | Jefferson .....  | 28  | Ross .....       | 22   |
| Clermont .....   | 9   | Knox .....       | 11  | Sandusky .....   | 12   |
| Clinton .....    | 8   | Lake .....       | 19  | Scioto .....     | 20   |
| Columbiana ..... | 12  | Lawrence .....   | 7   | Seneca .....     | 12   |
| Coshocton .....  | 4   | Licking .....    | 17  | Shelby .....     | 7    |
| Crawford .....   | 9   | Logan .....      | 8   | Stark .....      | 101  |
| Cuyahoga .....   | 787 | Lorain .....     | 39  | Summit .....     | 162  |
| Darke .....      | 6   | Lucas .....      | 182 | Trumbull .....   | 27   |
| Defiance .....   | 4   | Madison .....    | 6   | Tuscarawas ..... | 20   |
| Delaware .....   | 7   | Mahoning .....   | 141 | Union .....      | 2    |
| Erie .....       | 11  | Marion .....     | 16  | Van Wert .....   | 9    |
| Fairfield .....  | 9   | Medina .....     | 13  | Vinton .....     | 2    |
| Fayette .....    | 2   | Meigs .....      | 3   | Warren .....     | 4    |
| Franklin .....   | 251 | Mercer .....     | 6   | Washington ..... | 8    |
| Fulton .....     | 6   | Miami .....      | 15  | Wayne .....      | 13   |
| Gallia .....     | 5   | Monroe .....     | 0   | Williams .....   | 8    |
| Geauga .....     | 4   | Montgomery ..... | 164 | Wood .....       | 19   |
| Greene .....     | 7   | Morgan .....     | 3   | Wyandot .....    | 3    |
| Total .....      |     |                  |     |                  | 3112 |

## Legislature To Be Asked for Funds for Enlarged Medical and Health Center at Ohio State University

Establishment of a medical and health center at Ohio State University at an estimated cost of \$5,000,000 will be asked of the 96th Ohio General Assembly, now in session at Columbus. The center was recommended by former Governor John W. Bricker in his last message to the legislature on Jan. 1 of this year. It is proposed that the legislature appropriate funds for the health center in addition to \$12,500,000 being requested for other postwar building projects at Ohio State University.

It is contemplated that the proposed medical center will include: a new building to house the College of Dentistry; an addition to Hamilton Hall, where the medical and dental colleges now are located, to provide adequate library facilities; an 800-bed addition to University Hospital, to furnish needed hospitalization facilities for Central Ohio and to bring clinical teaching opportunities up to minimum standards. At present the College of Medicine has two teaching hospital beds for each student, instead of six, as recommended by most medical educators.

A brochure citing the needs for the health center has been published by a public relations committee, consisting of Dr. Russel G. Means, chairman; Dr. Jonathan Forman and Dr. C. C. Sherburne, representing the medical profession; and Dr. Carl O. Boucher and Dr. Victor L. Steffel, representing the dental group.



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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### HAVE YOU SEEN YOUR LEGISLATOR ON PENDING PROPOSALS?

Up to the time this issue of *The Journal* went to press, approximately 60 bills having a medical or health angle had been introduced into the Ohio General Assembly.

Some of these proposals are worthy of the support of the medical profession. Representatives of the profession will appear before legislative committees to speak in favor of measures which will result in the improvement of the health of the people of Ohio.

On the other hand, some of the bills now pending would, if enacted, be detrimental to public health and medical standards, notably, proposals to permit those claiming to heal by prayer and spiritual means to engage in the healing art without regulation of any kind; a bill to license naturopaths—a new crop of healing art claimants; a measure to establish a separate board to examine and license chiropractors. These bills will be opposed by the medical profession.

To assume that because representatives of the Ohio State Medical Association in Columbus will express disapproval of these proposals, they will be defeated, is carrying optimism to the nth degree. In the final analysis, the spade work must be done back home. Members of the General Assembly are concerned about what the people in their respective communities think of these bills and most of them will be guided accordingly.

To put it bluntly: Your legislator wants to have your opinion on these and other proposals. Speak up. Tell him how you feel. See him or write him now. Tomorrow may be too late. Get in touch with the Legislative Chairman of your County Medical Society for specific information on these measures.

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### RED CROSS AND CRIPPLED CHILDREN'S PROGRAMS

During the month of March, physicians will be asked to make a financial contribution to two extremely worthwhile programs—the Red Cross War Fund and the Easter Seal Sale of the Ohio Society for Crippled Children.

Little need be said regarding these two voluntary enterprises as they have proved their merit throughout the years.

A contribution to both of these programs is a boost for the American way of helping the unfortunate and handicapped—through voluntary non-official action.

### DOCTORS AND FARMERS SHOULD PULL TOGETHER

During 1944, *The Ohio State Medical Journal* devoted a considerable amount of space to articles dealing with the health and medical problems of residents of rural areas. This was done for a purpose, namely, to give Ohio physicians factual information and opinions from farm leaders; also to inspire the medical profession to give this big question constructive thought.

The question of improving rural health is becoming an increasingly vital one. It is important that the medical profession work shoulder to shoulder with farm organizations in trying to find the answers.

Writing in the February issue of *The Modern Hospital*, Alden B. Mills reviews in his article, "The Farmer Takes a Stand for Better Health and Medical Care", actions which have been taken recently by certain farm groups. Mills draws these conclusions:

"Rural people are taking a greater interest in rural health problems than ever before and probably will insist that effective steps be taken."

"They will probably be ready to cooperate with hospital associations and the medical profession insofar as the latter will be aggressive in promoting remedies. If the professional groups won't meet the problems, the laymen will attempt to do so themselves."

"Farm people are thinking in terms of (a) more doctors, nurses and other professional personnel in rural areas; (b) increased hospital and clinic facilities with these directed more toward preventive medicine; (c) wider understanding of existing prepayment, nutritional and public health programs by rural people, and (d) more study of rural health problems and their solutions."

"The older farm organizations are quite distrustful of federal participation in the regular operation of medical care programs; the Farmers' Union, however, is supporting the Wagner-Murray-Dingell Bill. \* \* \* All of the organizations appear to favor federal aid for the construction of needed hospital, clinic and public health facilities, provided these funds are disbursed under local control. \* \* \*

"Many local farm groups are actively cooperating with Blue Cross plans. Running through their literature, however, are criticisms of the lack of hospital facilities which prevents full use of the Blue Cross and disappointment that Blue Cross does not yet include medical care."

These observations should give the medical profession something to think about.

If the farmer needs and wants better health and medical care, it is the responsibility of the medical profession to help him get it.

The solution is not easy to attain. But, at the

outset the profession can do the farmer a good turn by showing him the difference between good medical care and cheap medical care. It can warn him against steps which would lower, rather than raise, health standards. It can show him that the only solution for some of his health problems is by finding solutions for certain basic social and economic problems which exist in many rural areas.

There is much which can be accomplished through a meeting of minds on this important question. There is no better place to start than at the grass roots—at the county level. Plans to consider this matter from a state level are in the making.

### P.T.A. ON RIGHT TRACK; IT DESERVES OUR HELP

The January issue of *The Ohio Parent Teacher*, official publication of the Ohio Congress of Parents and Teachers, Inc., was devoted primarily to the health program of the organization.

Theme of the health program of the congress is "Build Positive Health", for as Mrs. Florence Martin, director of the Department of Health of the organization points out, "our best approach to health is from the preventive side".

The issue is full of excellent suggestions on ways to promote a good health program in every community.

In our opinion the P.T.A. is on the right track and is doing a constructive job. It deserves the support of the medical profession, individually and collectively. It has welcomed the guidance of the medical profession from a state level and we believe the local units will welcome similar action from the local level. Let's see that they get cooperation and guidance.

### IS THE BATTLE IN CALIFORNIA A TREND?

Thirteen bills relating to some phase of state medicine, compulsory sickness insurance or voluntary sickness insurance are pending in the present California General Assembly.

A review of some of these measures was published in the February 17 issue of *The Journal of the A.M.A.* It should be read by all physicians.

One of the proposals is being sponsored by the C.I.O.; another has the blessing of Governor Warren. The California Medical Society is sponsoring a bill which would aid and assist existing voluntary medical insurance programs.

Yes, most anything can happen in California. Nevertheless, the medical profession dare not close its eyes to happenings in California or any

other state. Is there a trend? Are sound and widespread voluntary medical insurance plans the only answer to public demand? They may not satisfy the rabid advocate of governmental programs but they may satisfy the greater part of the people.

Isn't it time for Ohio and other states where little progress has been made along voluntary lines to get busy—in a hurry?

This question may be submitted to the medical profession of Ohio before long by the State Association. When that time comes, the matter deserves studious consideration by every physician.

### THEY'RE NOT BAD GUYS WHEN, AND IF, YOU KNOW THEM

Writing in *Hygeia*, Dr. Morris Fishbein praises the American press for its increasingly active role in promoting the health of the people and points out that "the good that can be done by the newspapers of this country in relation to the advancement of medical care is simply incalculable".

How's the relationship between your local medical society and your local editors?

The activities of a local medical society are news. Are your local newspapers printing it?

Has your society a committee to cooperate with your local editors in seeing that they are informed of the activities and actions of your medical society? Don't you think it would be well to have such a committee if you don't have one now? Most newspapers are up against a manpower shortage problem. No doubt they would welcome the cooperation of such a committee.

Cooperation with reporters and editors is the best insurance of having events involving your medical society reported accurately. A good reporter will respect confidences. He'll make every effort to be accurate if supplied with all the facts. On the other hand, if brushed off, he'll run down the story from all possible sources which means he may go haywire.

The only editorials which amount to anything are those based on facts or sound logic. Most editors have no desire to spank doctors or to cast the medical profession in a bad light before their readers. However, they don't like to have the medical profession hold out on them or take an ostrich-like position on questions which are of genuine public interest, i.e., medico-social and economic questions. Has your society tried discussing some of these matters "off the record" with your local editors? Even an editor doesn't know all the answers. Neither does a doctor.

Medicine and the press, working together, can be potent factors in promoting health along proper channels. It's something for every county medical society to think about.



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\* In the development of the combat unit we had the cooperation of the following:

The Aero-Medical Laboratory, and the Proving Ground Command of the Army Air Forces; the Medical Research Section of the Bureau of Aeronautics of the United States Navy; the National Research Council's Committee on Acceleration, members of which are associated with the Mayo Clinic, Johns Hopkins, Banting Institute, Yale University—and other



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# WAR NOTES

Col. Derrick T. Vail, Cincinnati, senior consultant in ophthalmology for the European Theater of Operations since 1942, has returned to this country and is now on temporary duty in the Office of the Surgeon General. While serving in ETO, Col. Vail organized departments of ophthalmology in all the hospitals in that theater and encouraged the development of the artificial eye which the Army has found superior to glass eyes.

\* \* \*

According to a newspaper story, Maj. Robert F. Donley, Columbus, is C.O. of the 56th Field Hospital, which is housed in "an incredible French chateau, with huge chandeliers overhead and walls covered with oil paintings and many-hued tapestries".

\* \* \*

Lt. Col. Beecher L. Smith, Columbus, is C.O. of a general hospital somewhere in New Guinea. He reports having seen two other Columbusites, Capt. Willard B. Andrus recently, and Maj. Harrison S. Evans last August.

\* \* \*

Lt. Col. Frank T. Moore, Cuyahoga Falls, was reported wounded in action on Leyte Island.

\* \* \*

Bits of news about Youngstown medical officers from the *Bulletin of the Mahoning County Medical Society*: Maj. T. J. Tims, in France, near Paris, spent his third consecutive Christmas away from home. . . . Capt. Henry Sisek, in the Philippines, the invasion of which started on his birthday. . . . Capt. Barclay M. Brandmiller, also in the Philippines, as is Maj. John S. Goldcamp. . . . Lt. Comdr. J. H. Fisher, aboard the U.S.S.(?) on Christmas Day. . . . Maj. S. R. Cafaro, home on leave, told the staff of St. Elizabeth Hospital of his experiences as assistant chief surgeon at a base hospital in England. . . . Lt. Comdr. Wm. H. Evans, after 22 months on sea duty in the South Pacific, now assigned to the U.S. Naval Hospital, Norfolk, Va. . . . Capt. Henry C. Marsico, a patient at Deshon General Hospital, Butler, Pa., after 20 months overseas. . . . Lt. Comdr. Stanley Myers convalescing at Chelsea Naval Hospital, Boston. . . . Lt. Comdr. John A. Renner, now stationed at Great Lakes, Ill., after two years sea duty. . . . Capt. Nathan D. Belinky, prisoner of the Japanese since the fall of Corregidor, is alive and well and working in a hospital, according

The "Manpower Problem", plus the limitation of the number of hours in any one day to 24, precludes individual acknowledgment of the many fine letters from members in military service, expressing appreciation of receipt of the 1945 membership card in the Ohio Medical Association and The Journal. Officers of the Association and members of the State Headquarters Staff are sincerely grateful for these letters. All we ask in return is that you advise us promptly of changes of address and send news for "War Notes".

to an enemy propaganda broadcast. . . . Capt. Clarence J. Duby, on the staff of a general hospital in France.

\* \* \*

Maj. Howard W. Brettell, Steubenville, whose active Army service began with the 37th Division back in 1940, returned to civilian practice in Nov., 1941. He re-applied for a commission and reported for duty at Billings General Hospital, Ft. Benjamin Harrison, Ind., in Nov., 1942. Later assigned to an auxiliary surgical group, he was in plenty of action in North Africa and now is with the same group in France.

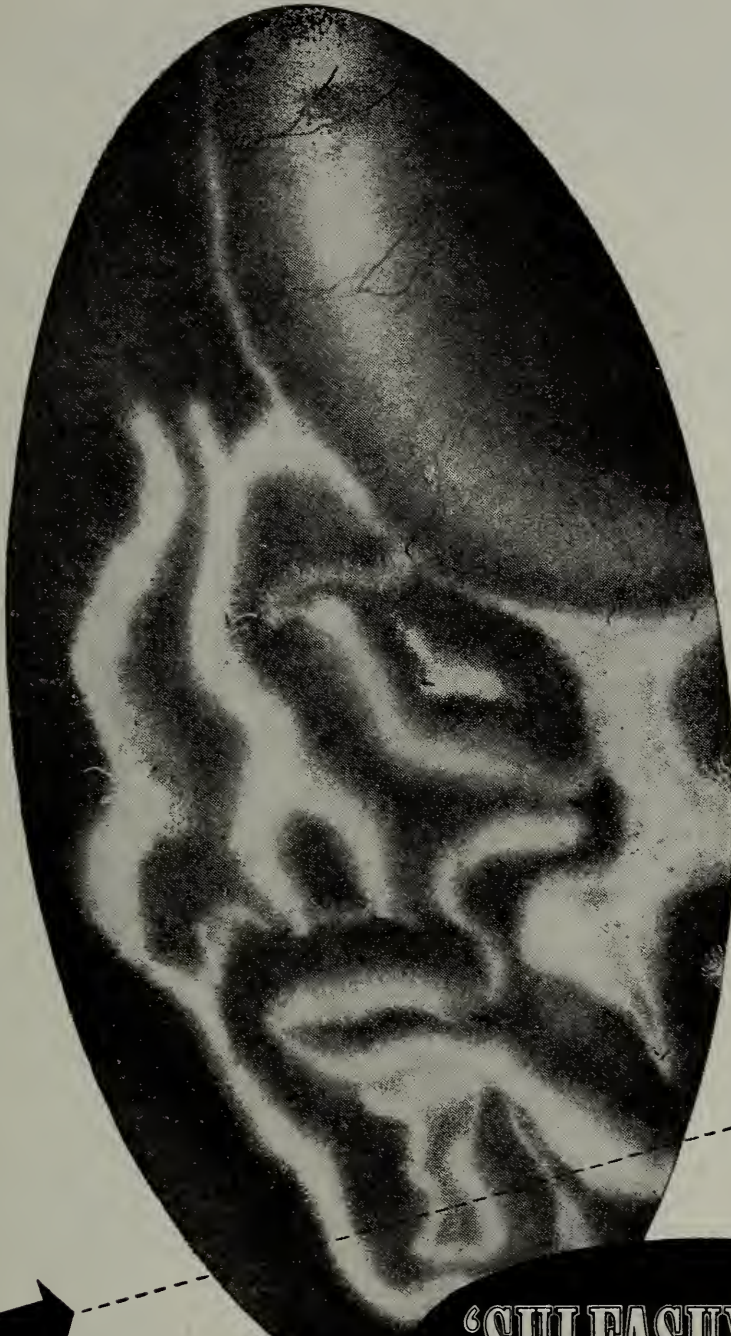
\* \* \*

Capt. Edward H. Cushing, M.C., U.S.N.R., Cleveland, has been awarded the Typhus Commission medal for distinguished service in an overseas disease-fighting assignment. The citation reads: "For meritorious service in connection with the work of the United States of America Typhus Commission. On Capt. Cushing, the first executive officer of the commission, fell the responsibilities of administering and directing the work of the commission in the early months of 1943. To the contribution which Capt. Cushing has made to the planning of the first overseas expedition of the United States of America Typhus Commission, he added personal service of high order in his forceful and tactful administration of the activities of the commission during a difficult period at its first station in the Middle East."

\* \* \*

Maj. Charles U. Hauser, now on the orthopedic staff at Deshon General Hospital, Butler, Pa., recently addressed his former associates at





Clinical reports continue to indicate the superiority of 'Sulfasuxidine' succinylsulfathiazole as an exceptionally effective enteric bacteriostatic agent. A recent report on the drug's effectiveness in combating an epidemic of bacillary dysentery states "Succinylsulfathiazole has been used . . . with better results than another intestinal sulfonamide."<sup>1</sup>

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1. Hawaii Medical Journal, Vol. 3, No. 5, pp. 222-226, May-June 1944.



**'SULFASUXIDINE'**

*Succinylsulfathiazole*

Bethesda Hospital, Cincinnati, on the subject: "Fractures of the Tibia from the Standpoint of War Casualties".

\* \* \*

About Toledoans in the service: Capt. Francis W. Epstein, wounded, not seriously, by shrapnel, while with the Third Army near Metz; now convalescing in a hospital in England. . . . Maj. Bernard Craw, assistant chief of receiving and evacuation dept., at Stark General Hospital. . . . Capt. W. A. Baird, somewhere out there in the South Pacific, "sweating out rotation" . . . Capt. Robert C. Suttle, who was "rotated" after three years in the Pacific, and is now at Robins Field, Ga. . . . Maj. Russell L. Shively, chief of surgery in a large surgical hospital in the ETO. . . . Capt. D. K. Levin, with an evacuation hospital, received the Purple Heart for damage done by the Germans, but back on the job next day.

\* \* \*

Mrs. Julie E. Goodman, Cleveland, mother of Capt. Julien M. Goodman, a prisoner of war since the fall of Bataan and Corregidor, writes that she received a Japanese Army postal card from him on Jan. 15, in which he said he was in good health, sent greetings to his family, and hoped to see them real soon. We hope his wish comes true, and maybe it will, because he was located at Prison Camp No. 8, 25 miles from Manila in the jungle mountain region. Mrs. Goodman has filed the issues of The Ohio State Medical Journal, along with his membership cards to be presented to him on his return.

\* \* \*

Maj. E. R. Jacka, Bryan, for over a year president of the Final Medical Board at the Armed Force Induction Station, Pittsburgh, reports an interesting letter from Capt. George H. Lemon, formerly of Fayette, now "somewhere along the Ledo Road". Capt. Lemon is doing air evacuation work in that theater, having completed some 400 flying hours since July 5, 1944. Some of the evacuation trips have been from the front lines in Burma, all the way across India to Karachi.

\* \* \*

For his care and treatment of wounded men under heavy artillery and aerial bombardment in France, Belgium and Holland, Capt. O. L. Coddington, Columbus, with an artillery outfit, has been decorated with the Bronze Star Medal.

\* \* \*

Lt. Col. John H. Marshall, Findlay, executive officer of Crile General Hospital, Cleveland, gave a lecture on "Tropical Diseases", to his former Hancock County colleagues, their wives, and nurses from the Findlay Hospital, Feb. 8, at the

Elks' Club, Findlay. Col. Marshall's remarks were based on his experiences during two years in Australia and New Guinea. Before returning to this country he was C.O. of an Army hospital in Australia.

\* \* \*

Lt. Col. Roland S. Jauch, Cleveland, is executive officer of a general hospital in France.

\* \* \*

Capt. John M. Wilcox, Cleveland, is on duty at an air base dispensary near Anchorage, Alaska.

\* \* \*

On the first list of prisoners freed from Camp Cabanatuan, Luzon, appeared the name of Capt. Ralph E. Hibbs, Cleveland.

\* \* \*

Capt. Myron E. Crawford, Cleveland, hopes to stay a while "in a general hospital in France, which is as big, well-equipped and furnished as any in Ohio". Another Clevelander, Capt. Wm. Dreyfuss, is on the same staff, and Maj. Rufus A. Snyder, Portsmouth, is in the unit being replaced by Capt. Crawford's.

\* \* \*

Comdr. Drew L. Davies, Columbus, Base Medical Officer at a large Naval base in the South Pacific, has three jobs: heads up all naval medical activities at the base; is officer-in-charge of a large medical storehouse, and last but not least, is on the staff of a two-star Admiral.

\* \* \*

Lt. Comdr. E. R. Brubaker, Springfield, has been senior medical officer of the Navy Recruiting Station, Cincinnati, since 1942.

\* \* \*

Maj. John H. Falk, Cincinnati, with a field hospital in the Southwest Pacific, sends his new address, because he has been getting *The Journal* regularly and "would hate to miss it", bless him!

\* \* \*

Maj. Harold K. Goler, Cleveland, was recently transferred from the Station Hospital, Ft. Lewis, Wash., to the Madigan General Hospital, Tacoma, where Lt. Col. York N. Pitkin, Cleveland, is chief of the ENT Department.

\* \* \*

From an artillery outfit with the 1st Army, "a little south of Aachen", Capt. F. W. Kaylor, Bellefontaine, V-mails that he enjoys reading *The Journal* very much, but he hasn't had a copy for several months. Inasmuch as his address is O.K. on our mailing list, we must conclude that Gen. Von Runstedt, et al., are guilty of disrupting the mail service, along with other crimes.

\* \* \*

Recently assigned as chief of the section of obstetrics and gynecology at the Regional Hos-



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pital, Ft. Knox, Ky., Lt. Col. Arthur G. King, Cincinnati, writes:

"The volume of work amazed me, accustomed as I was to think of the Army in terms of fighting men. Over 300 women are registered in the clinics which are held three times a week. The equipment is excellent, and the service includes a large delivery suite, a three-room nursery, two wards, and several private rooms. It is a very welcome change from the overseas' administrative work that occupied me so long. It is the Army policy to assign men within their specialties whenever possible, although military necessities naturally govern changes; and it should be encouraging to any of the men not happy in their present assignments to know that the policy is being followed to the greatest extent possible. Overseas *The Journal* reached me many months late, and it is a pleasure to continue to receive it, on time now, with its many interesting features of current importance."

\* \* \*

For meritorious service last year, the Bronze Star Medal has been awarded to Col. Marshall M. Best, Xenia, now stationed in France. Accompanying the award was a citation from Brig. General William L. Richardson, which complimented Col. Best for his "ingenuity, enthusiasm and skill" as command surgeon of the Ninth Air Service Command.

\* \* \*

Comdr. Henry P. Worstell, Columbus, recently transferred to another post in Australia, is now senior medical officer at a naval base dispensary. Pleasant life, he reports, but would prefer moving up to the Philippines. (The snapshot you sent got by the censors, Henry. Right appropriate place for that prophylactic station sign.)

\* \* \*

Capt. Carl A. Hamann, Jr., Cleveland, is home for reassignment after nearly three years with the Lakeside Unit in the South Pacific.

\* \* \*

News from the *Bulletin of the Cleveland Academy of Medicine* about some of their military members: Capt. Frank R. Hall, awarded the Bronze Star medal for meritorious service as neurosurgeon with the 45th Evacuation Hospital in France. . . . Maj. Marvin G. Sadugor, chief of surgery, McClellan Field Hospital, Sacramento, Calif. . . . Maj. J. H. Lazzari, chief of surgery at a 2000-bed hospital in the South Pacific. . . . Capt. Thomas S. King, doing surgery in an evacuation hospital in Luxembourg. . . . Capt. J. F. Martin, roentgenologist in the Russell Islands. . . . Capt. A. M. Leigh, in an advanced field hospital in France. . . . Lt. (j.g.) Lester Parker, Jr., and Lt. (j.g.) Pat Shea serving on destroyers in the Pacific. . . . Lt. James Greetham, landed in England. . . . Maj. Robert Holmberg, back in England, after two weeks at home, reports frequent visits with Capt.

Milt Bobey, now in France, as is Capt. Jacob Werle. . . . More Lakeside Unit men returned recently for reassignment: Maj John Thornton, Capt. Eldon C. Weckesser, Capt. William Markley, Maj. Ed. Harper and Maj. Boyd King.

\* \* \*

Lt. Herman W. Mannhardt, Bowling Green, recently at the U.S. Naval Hospital, Farragut, Idaho, is now on his second tour of sea duty.

\* \* \*

Capt. William G. Meyer, Columbus, is with a general hospital unit on the island of Oahu, and reports enjoyable visits to Honolulu and that beach at Waikiki.

\* \* \*

Col. Rex M. McDowell, D.C., assistant director of the Dental Division, Office of the Surgeon General, has been recommended for promotion to Brigadier General. A native of McDowell, Ohio, Col. McDowell received his D.D.S. degree from Ohio State University in 1916. He entered the Army the same year as a dental surgeon. He was appointed Major in 1917, Lieut. Col. in 1936 and Colonel in 1941.

\* \* \*

Lt. Comdr. R. E. Pumphrey, Dayton, is now on an assault transport in the Pacific, "which promises to be an interesting duty".

\* \* \*

Comdr. Herbert P. Lyle, Norwood, has been on duty at the U.S. Naval Hospital, Portsmouth, since April, 1942. Other Ohioans on the staff are: Comdr. Judson D. Wilson, Columbus; Lt. Comdr. John B. Toepfer and Lt. Stewart A. Schloss, Cincinnati.

\* \* \*

Capt. John A. Riebel, Ashland, is in charge of officer-patients having orthopedic and neurosurgical lesions, at the Welch Convalescent Hospital, Daytona Beach, Fla. It is a 2,000-bed hospital, expanding to 4,000, for the rehabilitation and convalescent care of the returnees from the general hospitals of the Fourth Service Command.

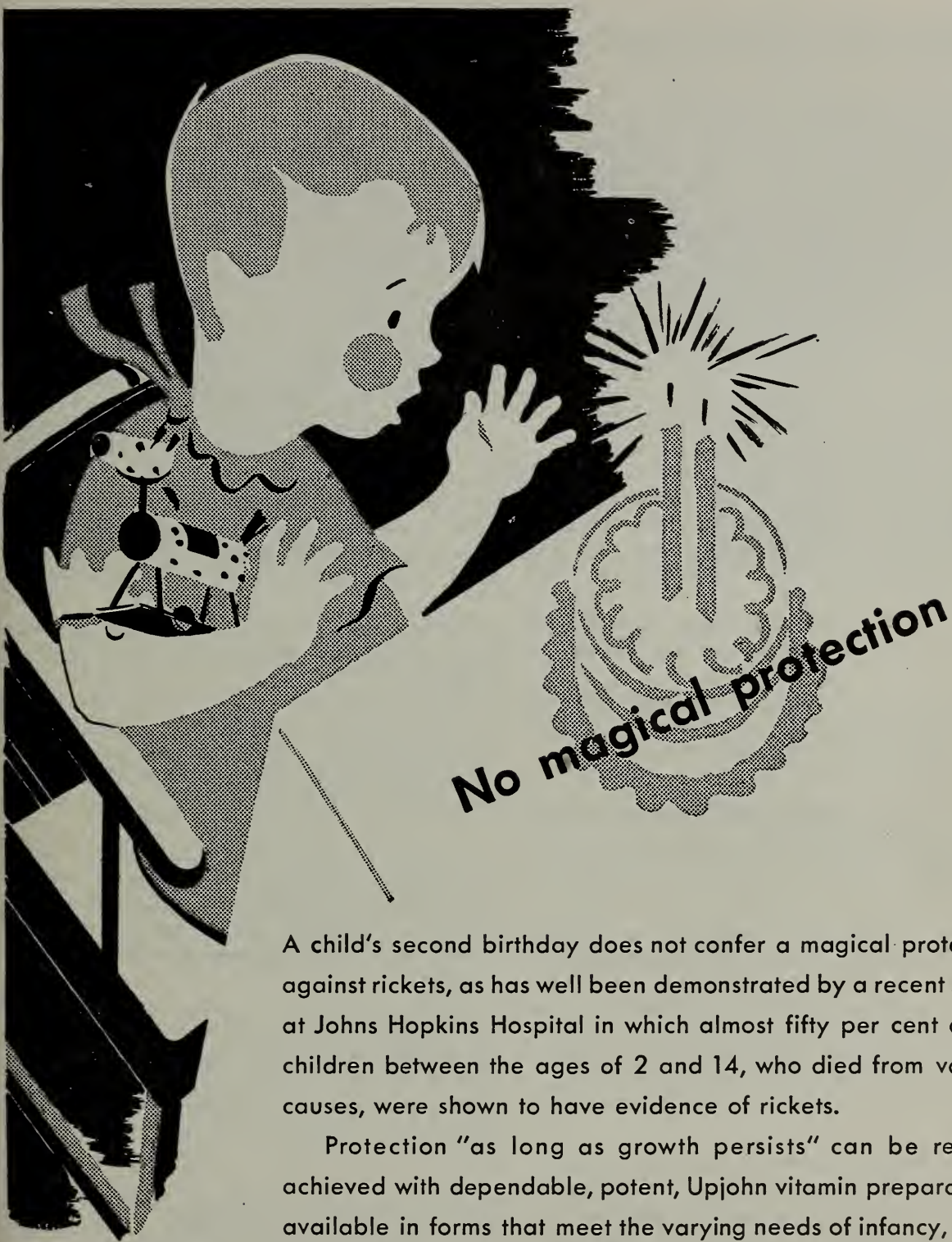
\* \* \*

After two years at McCloskey General Hospital, Temple, Texas, as assistant chief of neuropsychiatry, Maj. William Roach, N. College Hill, has been transferred to a senior position in the neuropsychiatric department of the AG and SF Redistribution Station, Medical Branch, Hot Springs, Ark.

\* \* \*

Bits of news about Dayton medical officers from the Montgomery County Medical Society news-letter: Capt. S. F. Markey, home on leave and a patient at Fletcher General Hospital, Cambridge. . . . Maj. Wm. R. Althoff, also home on leave, was in a hospital with malaria. . . . Others home on leave, Maj. R. E. Tyvand and Capt. Peary Berger. . . . Drs. Roy Arn, Dick Hochwalt and Reed Prugh are on Leyte. . . .





A child's second birthday does not confer a magical protection against rickets, as has well been demonstrated by a recent study<sup>1</sup> at Johns Hopkins Hospital in which almost fifty per cent of the children between the ages of 2 and 14, who died from various causes, were shown to have evidence of rickets.

Protection "as long as growth persists" can be readily achieved with dependable, potent, Upjohn vitamin preparations, available in forms that meet the varying needs of infancy, childhood, and early adolescence.

1. Am. J. Dis. Child. 66:1 (July) 1943.



## Upjohn Vitamins

DO MORE THAN BEFORE—KEEP ON BUYING WAR BONDS

Capt. R. C. Miller, in "Merrie?" England, where the weather is "damnable". . . . After five months in England, Capt. Louis B. Katz has been in France since July on the surgical staff of an evacuation hospital. . . . Lt. Comdr. L. J. Newell, after four months at Pensacola taking a course in aviation medicine and flight training, now at Deland and due to go to sea. . . . Maj. W. R. Hochwalt, "somewhere in the Philippines", where the going is pretty rough and where he "really never expected to be this close to actual war in a general hospital". . . . Capt. Chas. Wine passed through Paris just a few days after its liberation. His unit has been operational in France since shortly after D-day and still is. . . . Capt. W. Gitman at a POW camp in Huntsville, Texas, in charge of German prisoners (medically), with five German doctors on his staff.

\* \* \*

Col. Herbert B. Wright, Cleveland, chief of professional services in the medical department of the U.S. Strategic Air Forces in Europe, has won the Bronze Star for "meritorious service in connection with military operations". Col. Wright was a sergeant in the medical corps during World War I.

\* \* \*

Capt. C. B. Schoolfield, Upper Sandusky, is with a general hospital unit on Biak Island.

\* \* \*

Returned from LST and European duty, Lt. (j.g.) William E. Sovik, Youngstown, is at the U.S. Naval Hospital, Memphis, Tenn.

\* \* \*

Lt. Robert G. Smith, Columbus, is on duty at the U.S. Naval Hospital, Norfolk, Va., after 21 months' service in the South Pacific aboard a battleship.

\* \* \*

Capt. L. J. Tilton, Frazeysburg, writes that while he was in the field up until a couple of months ago with an armored regiment in the Third Armored Division, he didn't have much time to read, but following recovery from an illness he has been reassigned to a general hospital unit. Now that he's in "a settled quiet atmosphere", he wants *The Journal*.

\* \* \*

The Bronze Star Medal has been awarded to Lt. Col. Ralph H. Shilling, Columbus, for his work as commanding officer of a medical battalion in France and Belgium, from June 21 to Aug. 18, 1944. Col. Shilling entered the service Jan. 7, 1942. He has been abroad since Dec., 1943.

\* \* \*

Lt. Col. Charles S. Higley, Cleveland, who has been CO of the 750-bed AAF Regional Hospital, Truax Field, Madison, Wis., for 13 months, reports that there are a number of other Ohioans stationed there. From Cleveland are: Lt. Col. B. B. Larsen, chief of surgical service; Maj. Emil F. Ersay, flight surgeon; Capt. Wil-

liam E. Forsythe, urologist; Capt. George W. Bennett, Capt. William J. Flynn and Capt. Andrew J. Karson, dispensary officers. Cincinnatians on the staff are: Capt. James S. Caldwell, anesthetist, and Capt. Henry C. Beekley, ward surgeon and professional consultant to the Convalescent Training Program. From Columbus are Capt. Richard W. Zollinger, assistant chief of surgical service, and Capt. Howard W. Mahaffey, orthopedist. Maj. Frederick S. Coombs, Jr., Youngstown, is chief of the laboratory service.

\* \* \*

There's quite an Ohio colony on the staff of the AAF Station Hospital, Greensboro, according to Capt. John M. Wilkins, Marysville, chief of dispensary service. He mentions: Maj. Kay Liber, Canton, chief of the orthopedic section; Maj. Sam Hantman, Cleveland, cardiologist and on the medical service; Maj. F. W. Clement, Toledo, chief of anesthesia; Capt. Courtney L. Jack, Cincinnati, on the neuropsychiatry staff; and Capt. H. F. Kesinger, McArthur, immunization officer.

\* \* \*

Lt. Col. Roland S. Jauch, Rocky River, is executive officer of a 1,000-bed general hospital in England.

\* \* \*

From the Palau Islands, Lt. Comdr. W. F. Lyons, Coshocton, reports his new address. He was formerly medical officer for the V-12 Naval Unit at Ohio Wesleyan University, Delaware.

\* \* \*

Returned to the States in November after 29 months with the 37th Division in the Fiji Islands, Bougainville and Guadalcanal, Maj. E. L. Montgomery, Circleville, is a patient at Fletcher General Hospital, Cambridge.

\* \* \*

Maj. Robert Perlman, Cincinnati, is chief of the orthopedic section at Rhoads General Hospital, Utica, N.Y. Associated with him in that section is Capt. John O'Bell, Ashtabula, and Capt. Louis C. Rettig, Columbus, is chief of the septic surgery section.

\* \* \*

We've heard tales of medical officers who received unexpected transfer orders while their families were en route to join them—but here's one such order that arrived while an officer was writing to his favorite medical journal. Read this from Maj. Theodore V. Gerlinger, Willard:

"Just a few lines to bring my brief Army career up to date in the best medical journal in the U.S.A. and 'Texas'. Since August 22, 1942, I have been camped in Texas, just north of the border at Camp Barkeley. During this time I have been fighting in the 'Battle of Barkeley' as chief of the septic and proctology surgery section in the local hospital. *The Journal* has been arriving regularly and just as regularly is being read from cover page to reprint page.



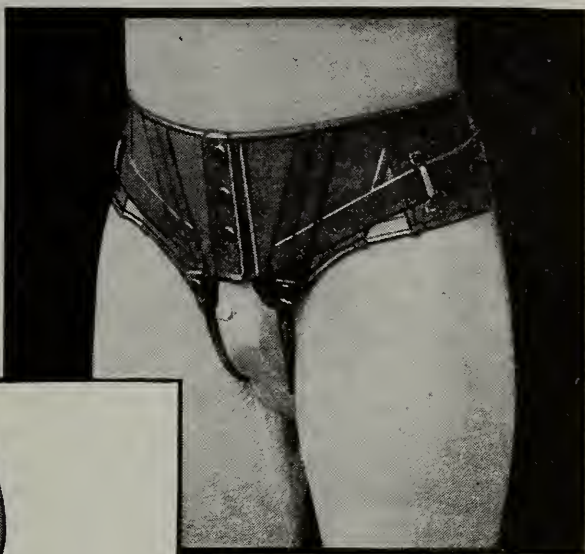
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The CAMP adjustable spring pad for use with the belt is equipped with prongs of piano wire. The strong flexible prongs fit firmly in the casings of the belt. Pads are available in varying shapes and depths.

The CAMP adjustment of the belt courses along the groin over the pad, hugging it in and up for the protection of the internal ring.

Surgeons who wish some protection over the area after operation will find this belt of particular advantage because the adjustment allows varying degrees of firmness about the lower abdomen.

May I comment that 'War Notes' is a great tribute to the medical officers in the armed forces, especially overseas, and deserves an Army E for excellence. In closing I would like to report my promotion to a Majority, effective December 2, 1944. Best wishes to the *Journal* staff for a happy and successful year.

"P.S. Here it is! While writing this letter I just now received orders for transfer to the 3818th SU, AG & SF Redistribution Station, Fort Sam Houston, Texas."

\* \* \*

In the service since Dec., 1940, and Chief of Neuropsychiatric Service at Battey General Hospital, Rome, Ga., since Oct., 1943, Lt. Col. Louis Pillersdorf, Cleveland, makes this timely comment:

"Since a large number of our patients are separated from the service we are particularly concerned with the readjustment of the soldier in his return to civilian life. This problem will have to be met in each locality and a working setup should be in operation NOW since this is not a postwar problem but one which has been with us from the time we started to expand the Army."

\* \* \*

Changes of location within the United States: Maj. William F. Ashe, Jr., Cincinnati, Acting Director, Nutrition Division, Office of The Surgeon General, Washington, D.C.; Lt. G. B. Ackerman, Columbus, 88th Field Hosp., Camp Ellis, Ill.; Lt. Henry Bachman, Delaware, 313th Gen. Hosp., Camp Cooke, Calif.; Capt. J. H. Bolotin, Warren, 94th Field Hosp., Camp Chaffee, Ark.; Maj. Jack A. Adelman, Columbus, AAF, Atlantic City, N.J.; Lt. S. L. Burkhardt, Steubenville, Navy V-12 Unit, State Teachers College, Valley City, North Dakota; Capt. Thomas F. Betts, Findlay, 173rd Coast Artillery Bn., Ft. Baker, Calif.; Maj. Theodore C. Allenbach, Columbus, 21st Med. Serv. Co., Ft. Lewis, Wash.; Capt. J. R. Buchanan, Youngstown, Ashburn Gen. Hosp., Camp McKinney, Texas; Lt. Col. John C. Blinn, New Philadelphia, Hq., 13th Med. Tng. Regt., ASFTC, Camp Barkeley, Texas; Lt. Col. R. J. Borer, Toledo, Hq. 36, MTRAS, FTC, Ft. Lewis, Wash.; Lt. R. H. Breneman, Akron, Hq., 555th Sq., Selfridge Field, Mich.; Capt. C. A. Cassady, Columbus, 199th Gen. Hosp., Camp Ellis, Ill.; Maj. Edw. B. Castle, Cleveland, Walter Reed Hospital, Washington, D.C.; Lt. Col. James H. Carson, Martins Ferry, 93rd Field Hosp., Camp Robinson, Ark.; Capt. Bernard K. Craw, Toledo, Stark Gen. Hosp., Charleston, S.C.; Capt. Donald C. Darrah, Cleveland, PAAF Sta. Hosp., Pecos, Texas.

Capt. Lincoln C. Dickey, Shaker Heights, ASF Person. Repl. Depot, Indiantown Gap Military Reservation, Pa.; Maj. Archie Fine, Cincinnati, AAF Conv. Hosp., Plattsburg, N.Y.; Capt. A. N. Freed, Shaker Heights, Reg. Hosp., Camp Maxey, Texas; Maj. William S. Elliott, East Palestine, Walker AAF, Victoria Kans.; Lt. Comdr. A. F. Errington, Akron, Epidemiology Unit 79, Seattle, Wash.; Col. Paul R. Ensign, Toledo, 8th SAFTC, Camp Barkeley, Texas; Maj. Morris B. Guthrie, Columbus, Sta. Hosp., Ft. McPherson, Atlanta, Ga.; Lt. Comdr. Robert S. Gillette, Toledo, Naval Air Gunners' School, Jacksonville, Fla.; Maj. Frank Gollan, Cleveland, Army Medical Center,

Walter Reed Hosp, Washington, D.C.; Capt. David L. Hirst, Miamisburg, 1534th S.U. Camp Atterbury, Ind.; Maj. Edgar B. Junkermann, Columbus, Hq., ASFTC, Camp Barkeley, Texas; Lt. Col. Burton E. Hyde, Troy, 894th Med. Prof. Serv. Det., Ft. Lewis, Wash.; Capt. E. M. Kilpatrick, Columbus, SCU 1915, Madigan Gen. Hosp., Ft. Lewis, Wash.; Lt. (j.g.) Eli J. Weller, Cincinnati, Great Lakes Naval Training Center, Great Lakes, Ill.

Maj. L. Burdette Wylie, Cleveland, ASFTC, Camp Barkeley, Texas; Capt. Angelo Lapi, Canton, 813 AAFBU, Sedalia AAF, Warrensburg, Mo.; Lt. Col. Charles L. Langsam, Macedonia, SCU 1447, Ft. Benning, Ga.; Lt. H. G. Knierim, Mansfield, MFS School, Camp Le Jeune, N.C.; Maj. H. Worley Kendell, USPHS(R), Dayton, Neurosyphilis Unit, Mississippi State Hosp., Whitfield, Miss.; Capt. J. R. Lutz, North Ridgeville, AAF, Columbus, Miss.; Capt. I. Leonard Levin, Sta. Hosp., Camp Hood, Texas; Capt. Howard H. Minor, Steubenville, Selman Field, Monroe, La.; Lt. R. P. Moon, Dayton, Hq., 4th Rgt., Indiantown Gap Military Reservation, Pa.; Capt. Chas. W. McGavran, Columbus, Mayo Foundation, Rochester, Minn.; Capt. Ray O. Nulsen, Cincinnati, Sta. Hosp., Camp Chanks, N.Y.

Lt. Col. States D. McCoy, Columbus, Hq., 15th Med. Tng. Regt., ASFTC, Camp Barkeley, Texas; Lt. John R. Nenninger, Cincinnati, Tampa, Fla.; Capt. R. C. Paisley, Loudonville, Reg. Hosp., Camp Shelby, Miss.; Capt. Harry J. Riemer, Cleveland, Sta. Hosp., Camp Roberts, Calif.; Maj. Thomas J. Rankin, Oxford, Sta. Hosp., Dale Mabry Field, Tallahassee, Fla.; Lt. Comdr. M. M. Riddell, Fremont, U.S. Naval Convalescent Hosp., Santa Cruz, Calif.; Lt. Ernst Sternfeld, Toledo, 135th Evac. Hosp., Camp Gruber, Okla.; Lt. Chas. M. Smith, Portsmouth, NAS, Deland, Fla.; Lt. Col. Norman C. Schroeder, Kenton, Vet. Admr. Fac., Dallas, Texas; Lt. Comdr. R. L. Slater, Canton, Naval Hosp., Philadelphia, Pa.; Maj. William T. Sharp, Chillicothe, Vet. Adm. Fac., Chillicothe; Capt. Geo. O. Thompson, Alliance, Fourth Service Command, Camp Wheeler, Ga.; Maj. Louis S. Zwick, Wadsworth, chief, Receiving and Disposition Section and the Out-Patient Branch, Billings Gen. Hosp., Ft. Benjamin Harrison, Ind.; Lt. Col. F. M. Wadsworth, Mansfield, Vet. Admr. Fac., Dayton; Maj. Wm. W. Trostel, Piqua, Vet. Admr. Fac., Atlanta, Ga.

\* \* \*

Following a jeep-truck accident in New Guinea in April, 1944, Capt. Luther N. Schroder, Greenville, was a patient at the Percy Jones General Hospital, Battle Creek, Mich., from July 1 to Dec. 1. Back to active duty, he is now chief of EENT at the AAF Redistribution Station No. 3, Santa Monica, Calif.

\* \* \*

Capt. Morris A. Krakoff, Columbus, is a member of a hospital unit which recently won a presidential citation for its work on Saipan.

\* \* \*

Lt. Col. Daniel C. Elkin, M.C., chief of surgical service, Ashford General Hospital, White Sulphur Springs, W. Va., was the guest speaker at the annual Frank E. Bunts Institute, Jan. 29, at the Cleveland Clinic. He discussed "Vascular Injuries of Warfare".



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# In Memoriam

**Frederick Dale Barker, M.D.,** Granville; University of Pennsylvania School of Medicine, Philadelphia, 1890; aged 85; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 15. A native of McConnelsville, Dr. Barker practiced in Dayton for 25 years, where he was division surgeon for the Baltimore and Ohio Railroad Co., and at one time chief of staff of Miami Valley Hospital. During World War I he served overseas 10 months as a captain in the Red Cross. Dr. Barker retired in 1922 and moved to Granville. He was a member of the Board of Trustees of Denison University, and a former chairman of the board of public works at Granville. Dr. Barker was a member of the Beta Theta Pi fraternity. His widow, two sons and a sister survive.

**Virgil F. Barker, M.D.,** Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 67; died Jan. 9. Dr. Barker traveled extensively in Europe until his retirement five years ago. He was a surgeon with the Marine Corps in World War I. Surviving are his mother and a sister.

**Robert James Beels, M.D.,** Cleveland; Bennett College of Eclectic Medicine and Surgery, Chicago, 1910; aged 66; member of the Ohio State Medical Association and the American Medical Association; died Feb. 2. Dr. Beels practiced in Cleveland for over 30 years. He was a past commander of the Glenville Post of the American Legion. Dr. Beels was a member of the Masonic Order and the Presbyterian Church. His widow, a sister and a brother survive.

**Charles Elton Blanchard, M.D.,** Youngstown; University of Wooster, Medical Department, Cleveland, 1902; aged 67; died Jan. 15. Dr. Blanchard practiced in Youngstown for 25 years. He was previously located in Cleveland.

**George Daniel Bollard, M.D.,** Jefferson; Western Reserve University School of Medicine, Cleveland, 1888; aged 85; died Jan. 3. After practicing medicine in Jefferson for eight years, Dr. Bollard for a number of years was employed by a wholesale drug firm in Cleveland. His widow survives.

**Walter Francis Coakley, M.D.,** Hamilton; Ohio State University College of Medicine, 1928; aged 53; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 6. A retired Army physician, Dr. Coakley served overseas 22 months during World War I. Two brothers and two sisters survive.

## DIED WHILE IN MILITARY SERVICE

**Seaton Sailer, M.D.,** Cincinnati; Long Island College of Medicine, Brooklyn, 1931; aged 39; member of the American Association of Pathologists and Bacteriologists; died in France, Nov. 24, 1942, of injuries accidentally incurred when struck by a truck along a highway. In charge of pathologic work at the 25th General Hospital, Lt. Col. Sailer was formerly assistant professor of pathology at the University of Cincinnati College of Medicine. He was commissioned a major on Feb. 19, 1942, and began active duty in June, 1942.

**William Peter Connor, M.D.,** Youngstown; Georgetown University School of Medicine, Washington, D.C., 1908; aged 67; died Jan. 20. One of the founders of St. Elizabeth Hospital, Youngstown, Dr. Connor retired several years ago because of poor health. His son, a sister and four brothers survive.

**Bonaparte P. Davis, M.D.,** Fort Jennings; Jefferson Medical College, Philadelphia, 1913; aged 55; member of the Ohio State Medical Association and the American Medical Association; died Jan. 21. Dr. Davis practiced in Fort Jennings for 29 years, and was previously located in Bowling Green, Ky., for a short time. He was secretary of the Putnam County Medical Society in 1938. Dr. Davis was a member of the Methodist Church. His widow, a daughter and a brother survive.

**John Elmer Detamore, M.D.,** Union City; Ohio Medical University, Columbus, 1898; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 31. Dr. Detamore practiced in Darke County for more than 40 years. He was a member of the United Brethren Church. Surviving are a daughter, a son and a brother.

**William L. England, M.D.,** Middletown; Columbus Medical College, 1881; aged 92; died Jan. 6. Dr. England retired a few years ago, after having practiced in Jewett and Harrison County for nearly 60 years. He was a member of the Methodist Church. Two sons and a sister survive.

**Samuel Orlin Gantt, M.D.,** Centerburg; Starling Medical College, Columbus, 1890; aged 84; member of the Ohio State Medical Association and Fellow of the American Medical Association;



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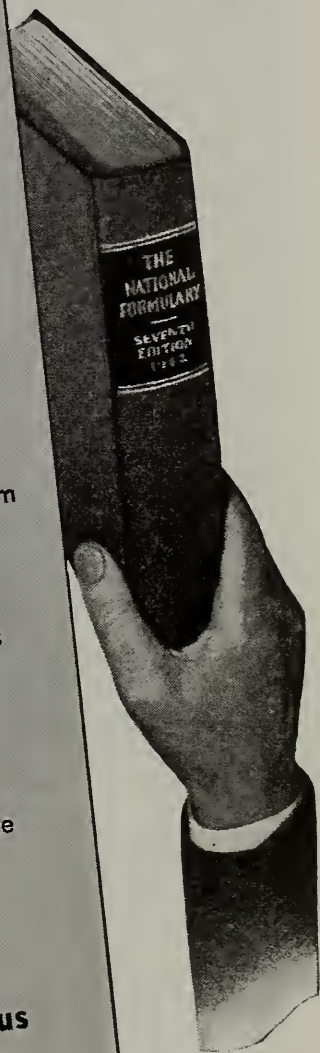
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died Dec. 31. A practicing physician for 54 years, Dr. Gantt was in Martinsburg for nine years and then opened an office in Centerburg. He was a former president of the Knox County Medical Society. Surviving are his widow and three sons.

**George Harper Holt, M.D., Cincinnati;** Miami Medical College, Cincinnati, 1902; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died Dec. 31. Dr. Holt retired a few years ago, after having practiced in Cincinnati for over 35 years. His widow survives.

**Leonard Carothers Nigh, M.D., Mansfield;** University of Cincinnati College of Medicine, 1923; aged 50; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Jan. 27. Dr. Nigh practiced in Mansfield for 20 years. His widow survives.

**Jacob C. Poling, M.D., Ansonia;** Miami Medical College, Cincinnati, 1905; aged 75; member of the Ohio State Medical Association and the American Medical Association; died Feb. 4. Dr. Poling practiced in Ansonia and Darke County for 40 years. Surviving are his widow and two daughters.

**Murray Mechling Rarick, M.D., Columbus;** Starling Medical College, Columbus, 1898; aged 72; died Feb. 15. Dr. Rarick retired recently after two years on the staff of the State Industrial Commission. Previously he had been on the medical staff of the Dayton State Hospital for 12 years, and physician for the Pennsylvania Railroad at Wellsville for 18 years. Dr. Rarick was a member of the Methodist Church, the I.O.O.F., and Knights of Pythias. Surviving are his widow, a son, a daughter, and a brother, Dr. Maurice S. Rarick, Thornville.

**Lawrence Martin Sifrit, M.D., Columbus;** Starling Medical College, Columbus, 1891; aged 75; died Jan. 25. Dr. Sifrit practiced in Harrisburg for 20 years, and since then had been located in Columbus. He was a member of the Knights of Pythias. His widow and a sister survive.

**John Joseph South, M.D., Massillon;** University of Pennsylvania School of Medicine, Philadelphia, 1914; aged 56; member of the Ohio State Medical Association and the American Medical Association; died Feb. 3. Chief of staff at the Massillon City Hospital, Dr. South had practiced there for 28 years. He was a medical officer with British troops during World War I. Dr. South was a member of the Catholic Church. His widow, a son and a sister survive.

**Charles Hugh Tate, M.D., Dayton;** Baltimore Medical College, Baltimore, Md., 1898; aged 70;

member of the Ohio State Medical Association and the Clinical Orthopaedic Society; Fellow of the American Medical Association; died Feb. 3. A past-president of the Montgomery County Medical Society, Dr. Tate practiced there for 40 years. He was a member of the staffs at Miami Valley, Good Samaritan, and St. Elizabeth hospitals. Dr. Tate was a Mason. His widow survives.

**Clarence Conkle Taylor, M.D., East Rochester;** Ohio Medical University, Columbus, 1898; aged 75; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Jan. 21. A practicing physician in Columbiana County for 42 years, Dr. Taylor took an active interest in community affairs. He was a member of the Methodist Church and the Masonic Order. Two daughters, two sons and five sisters survive.

**Van der Veer Taylor, M.D., Xenia;** Medical College of Ohio, Cincinnati, 1896; aged 79; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 13. Dr. Taylor retired in 1929 after having practiced in Cincinnati and Columbus. He was a former president of the Benjamin Franklin chapter of the Sons of the American Revolution, served on the council of the Society of Colonial Wars of Ohio, and was a member of the Lee Society of Virginia. Dr. Taylor was a member of the Presbyterian Church and a vice-president of the Greene County Historical Society. Two daughters, two sons and a sister survive.

**James Sprigg Wilson, M.D., Columbus;** University of Virginia, Department of Medicine, Charlottesville, 1892; aged 74; former member of the Ohio State Medical Association and the American Medical Association; died Jan. 15. Col. Wilson, a retired Army surgeon, served in the Spanish-American War and World War I. He was on duty in Cuba and the Philippines and from 1910 to 1914 was professor of tropical diseases at the University of Vermont. In 1918 and 1919 Col. Wilson was chief surgeon for the American Expeditionary Forces in Siberia and also was chief surgeon of the Inter-Allied Sanitary Commission. For two years prior to his retirement from active duty in 1922, he was surgeon for the Fifth Corps Area, with headquarters at Ft. Hayes. Col. Wilson was awarded the Distinguished Service Medal in 1922 for outstanding work in the Medical Department of the Army. In 1921 he received his M.S. degree in public health at Ohio State University, and in 1923 became assistant professor of public health, serving in that capacity until 1933. During 1932 and 1933 he was director of the student health service at the University. Surviving are his widow, a daughter, a son and two brothers.





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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### BROWN

Officers of the Brown County Medical Society for 1945 are: Dr. R. B. Hannah, Georgetown, pres., and Dr. Geo. P. Tyler, Jr., Ripley, secretary.

### BUTLER

Dr. C. E. Hauser, Cincinnati, member of the Ohio Procurement and Assignment Committee for Physicians, discussed the medical needs of Butler County, at a meeting of the Butler County Medical Society, January 25, at Mercy Hospital, Hamilton. Dr. J. C. Stratton, Mr. Andrew M. Clark and Dr. H. M. Moore, health commissioners of Middletown, Hamilton and Butler County, respectively, reported on their activities during 1944 and presented some current problems.—Garret J. Boone, M.D., president.

### CLINTON

Physicians from Adams, Brown, Clermont, Highland and Warren counties were guests at a meeting of the Clinton County Medical Society, February 6, at the General Denver Hotel, Wilmington. The Ohio State Medical Association's plan to organize a stock insurance company to provide indemnity against medical expenses was discussed by Dr. L. Howard Schriver, Cincinnati, the Association's President, and Dr. E. O. Swartz, Cincinnati, Councilor for the First District.—News clipping.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during February:

Feb. 6—"The Use of the X-ray in the Study of the Heart and Great Vessels", Dr. Merrill C. Sosman, clinical professor of roentgenology, Harvard Medical School, Boston.

Feb. 20—"The Surgical Treatment of Chronic Constrictive Pericarditis: a Postscript", Dr. George Heuer, professor of surgery, Cornell University Medical College, Ithaca, N.Y.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### CLARK

The following Springfield physicians are officers of the Clark County Medical Society for 1945: Dr. R. R. Richison, pres.; Dr. Edward Keefer, vice-pres.; Dr. S. C. Yinger, secy.; Dr. G. M. Lane, treas.; Dr. D. W. Hogue, chmn., Legislative Committee; Dr. W. P. Ultes, chmn., Committee on War Participation; Dr. R. B. Johns, chmn., Committee on Industrial Health; Dr. A. H. Potter, chmn., Committee on Recreation and Physical Fitness.

## MIAMI

"Thymus Gland Disease; Diagnosis and Treatment", was the topic discussed by Dr. W. P. Ultes, Springfield, at a meeting of the Miami County Medical Society, Feb. 2, at Stouder Memorial Hospital, Troy. A sound movie, "Sutures Since Lister", was shown through the courtesy of the Johnson and Johnson Company.—Geo. A. Woodhouse, M.D., secretary.

### MONTGOMERY

A forum on "Socialized Medicine" was presented at a meeting of the Montgomery County Medical Society, Feb. 2, at Dayton. Participants were: Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association; Dr. Geo. A. Woodhouse, Pleasant Hill, secretary of the Miami County Medical Society and a delegate from the State Association to the American Medical Association; Dr. Robert E. S. Young, Columbus, member of the State Association's Committee on Medical Service Plans; Lem E. Markland, representing the C.I.O.—Bulletin.

### SHELBY

Officers of the Shelby County Medical Society for 1945 are the following Sidney physicians: Dr. H. C. Clayton, pres.; Dr. A. B. Gudenkauf, vice-pres.; Dr. H. S. Elliott, secy.-treas.; Dr. Clayton, chmn., Legislative Committee; Dr. R. W. Alvis, chmn., Committee on War Participation and Committee on Industrial Health; Dr. Harry Crimm, chmn., Committee on Recreation and Physical Fitness.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### HANCOCK

A symposium on "Cholecystic Disease" was presented by Drs. John V. Hartman, H. P. Koehler and C. H. Evans, at a meeting of the Hancock County Medical Society, Jan. 18, at the Elks Home, Findlay. The following local physicians were elected officers of the society for 1945: Dr. Dwight J. King, pres.; Dr. E. E. Rakestraw, vice-pres.; Dr. Lena Enright, secy.; Dr. E. J. Thomas, treas.; Dr. D. B. Biggs, chmn., Legislative Committee; Dr. S. F. Whisler, chmn., Committee on Industrial Health; Dr. Rakestraw, chmn., Committee on War Participation; Dr. Ed. Misamore, chmn., Committee on Recreation and Physical Fitness.—L. S. Enright, M.D., secretary.

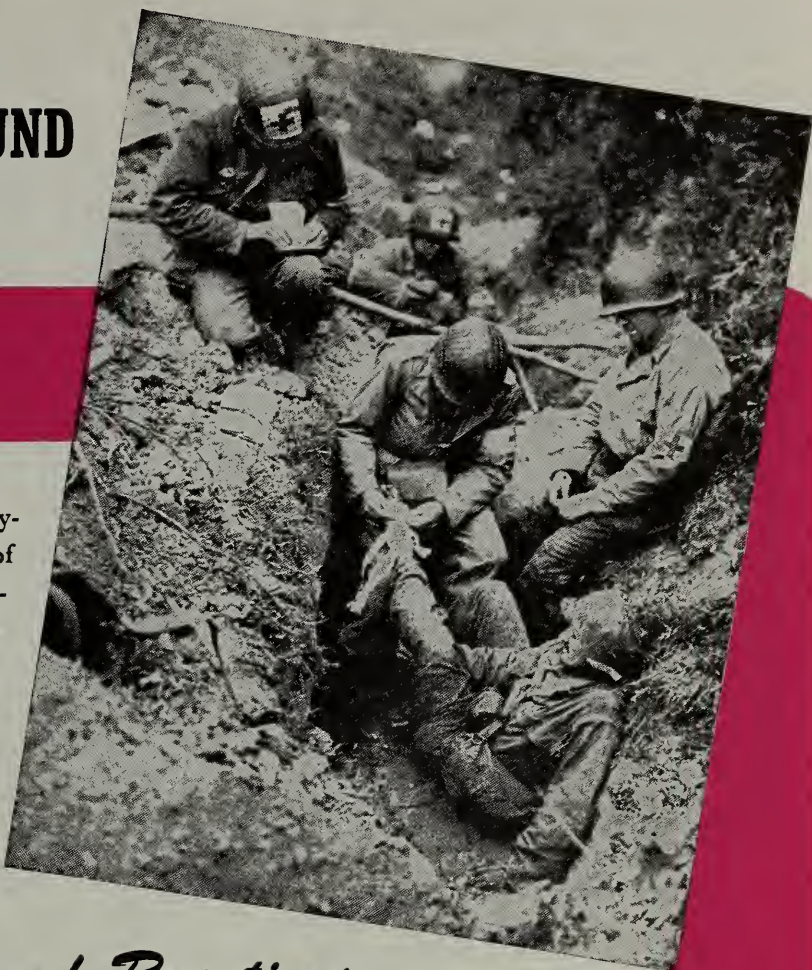
### LOGAN

Officers of the Logan County Medical Society for 1945 are: Dr. R. A. Firmin, Zanesfield, pres.; Dr. F. B. Kaylor, Bellefontaine, secy.-treas.; Dr. B. B. Blank, DeGraff, chmn., Legislative Com-



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\*MacFarlane, M. G.: The Therapeutic Value of Gas-Gangrene Antitoxin, Brit.M.J., 2:636-640 (1943).

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mittee; Dr. C. K. Startzman, Bellefontaine, chmn., Committee on War Participation and Policy; Dr. A. J. McCracken, Bellefontaine, chmn., Committee on Industrial Health.

#### MARION

Dr. George I. Nelson, professor of medicine, Ohio State University College of Medicine, Columbus, spoke on "Heart Disease", at a meeting of the Marion Academy of Medicine, Feb. 6, at the Marion City Hospital. The society voted to send a news bulletin to members in the armed forces.—News clipping.

### Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

#### FULTON

Officers of the Fulton County Medical Society for 1945 are: Dr. A. M. Wilkins, Delta, pres.; Dr. T. F. Smyth, Lyons, vice-pres.; Dr. L. C. Cosgrove, Sr., Swanton, secy.-treas.; Dr. L. E. Botts, Wauseon, chmn., Legislative Committee; Dr. Wilkins, chmn., Committee on War Participation; Dr. L. C. Cosgrove, Jr., Swanton, chmn., Committee on Industrial Health; Dr. E. R. Murbach, chmn., Committee on Recreation and Physical Fitness.

#### LUCAS

The Toledo Academy of Medicine presented the following programs during February:

Feb. 2—General Meeting. "Operation of a Newborn Nursery in a General Hospital", and "Diarrhea of the Newborn", by Dr. James L. Wilson, professor of pediatrics, University of Michigan Medical School, Ann Arbor.

Feb. 9—Section of Pathology. "Diagnostic and Prognostic Value of Hemograms in Infectious Diseases", Dr. John R. Phillips; "Chemistry of Bone Marrow", Albert A. Dietz, Ph.D.

Feb. 16—Medical Section. "Management of Acute and Chronic Diarrhea", Dr. H. M. Pollard, assistant professor of internal medicine, University of Michigan Medical School, Ann Arbor.—Bulletin.

Officers of the Academy for 1945 are: Dr. J. L. Stifel, pres.; Dr. E. C. Mohr, pres.-elect; Dr. Rollin Kuebbeler, secy.; Dr. W. W. Alderdyce, treas.; Dr. A. S. Avery, chmn., Legislative Committee; Dr. Dale Wilson, chmn., Committee on War Participation; Dr. R. H. Elrod, chmn., Committee on Industrial Health; Dr. R. C. Young, chmn., Committee on Recreation and Physical Fitness.—George W. Cooley, executive secretary.

#### PAULDING

Officers of the Paulding County Medical Society for 1945 are: Dr. Ray Mouser, Paulding, acting pres.; Dr. D. E. Farling, Payne, secy.-treas.; Dr. K. C. Evans, Payne, chmn., Legislative Committee; Dr. T. P. Fast, Grover Hill, chmn., Committee on War Participation; Dr. R. J. Dillery,

Paulding, chmn., Committee on Industrial Health; Dr. Evans, chmn., Committee on Recreation and Physical Fitness.

#### PUTNAM

The Putnam County Medical Society has elected the following officers for 1945: Dr. H. N. Trumbull, Columbus Grove, pres.; Dr. J. R. Echelbarger, Ottawa, vice-pres.; Dr. G. A. Sheppard, Ottawa, secy.-treas.; Dr. W. B. Recker, Leipsic, chmn., Legislative Committee; Dr. E. Blackburn, Kalida, chmn., Committee on War Participation.

#### WOOD

Officers of the Wood County Medical Society for 1945 are: Dr. F. V. Boyle, Bowling Green, pres.; Dr. F. L. Sterling, Bowling Green, vice-pres.; Dr. E. H. Mercer, Sr., Bowling Green, secy.-treas.; Dr. D. R. Barr, Grand Rapids, chmn., Legislative Committee; Dr. F. D. Halleck, Bowling Green, chmn., Committee on War Participation.

### Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

#### ASHTABULA

Dr. U. V. Portmann, Cleveland, spoke on "Carcinoma of the Breast", at a meeting of the Ashtabula County Medical Society, Dec. 12, at Ashtabula. The following officers were elected for the ensuing year: Dr. Wm. Millberg, Ashtabula, pres.; Dr. W. T. Lowry, Jefferson, vice-pres.; Dr. E. F. Lindenmayer, Ashtabula, secy.-treas.; Dr. R. B. Wynkoop, Ashtabula, chmn., Legislative Committee.

#### CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during February:

Feb. 2—Clinical and Pathological Section. "Hemorrhagic Disease and Splenectomy", Dr. H. C. Wise; "A Case of Tularemia Typhoidal Form", Dr. H. V. Paryzek; "A Diagnostic Problem of Hypertension", Dr. J. F. Slowey and Dr. F. A. Spittler; "A Case of Common Duct Obstruction Treated With Vitallium Tube", Dr. E. A. Mastics.

Feb. 9—Combined meeting, Western Reserve Chapter of the Society of Sigma Xi, Cleveland Section of the Society for Experimental Biology and Medicine and the Experimental Medicine Section of the Academy. "Genes and the Chemistry of the Organism", G. W. Beadle, Ph.D., professor of biology, Stanford University, San Francisco.

Feb. 28—Obstetrical and Gynecological Section. "Reactivation of Endometriosis by Stilbestrol Therapy", Dr. R. L. Faulkner; "Tuberculosis in Pregnancy", Dr. R. C. McKay.—Bulletin.

#### LAKE

Officers of the Lake County Medical Society for 1945 are: Dr. Mabel Pearce, Painesville, pres.;





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## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

New officers of the Mahoning County Medical Society include: Dr. W. H. Bunn, pres.; Dr. J. J. Reilly, pres.-elect; Dr. G. M. McKelvey, secy.; Dr. V. L. Goodwin, treas.; Dr. Wm. M. Skipp, chmn., Legislative Committee, all of Youngstown.—Mary B. Herald, executive secretary.

Dr. George M. Curtis, Columbus, spoke on "Recognition and Surgical Treatment of Bronchiectasis", at a meeting of the society, Feb. 20, at the Youngstown Club, Youngstown.—Bulletin.

### PORTAGE

Dr. F. R. Mautz, assistant professor of surgery, Western Reserve University School of Medicine, Cleveland, spoke on "Treatment of Burns, Medical and Surgical", at a meeting of the Portage County Medical Society, Feb. 8, at the Robinson Memorial Hospital, Ravenna.—E. J. Widdecombe, M.D., secretary.

Officers of the society for 1945 are: Dr. Joseph C. Fiala, Kent, pres.; Dr. Myron S. Owen, Ravenna, vice-pres.; Dr. Emily Widdecombe, Kent, secy.-treas.; Dr. Edgar H. Knowlton, Mantua, chmn., Legislative Committee; Dr. Paul H. Zinkhan, Ravenna, chmn., Committee on War Participation; Dr. John R. Turner, Kent, chmn., Committee on Industrial Health; Dr. Alfred J. Silbiger, Atwater, chmn., Committee on Public Relations and Economics.

### SUMMIT

Plans of the Ohio State Medical Association to form an insurance company to provide indemnity against medical expense were discussed by Dr. Edgar P. McNamee, Cleveland, President-Elect, at a meeting of the Summit County Medical Society, Feb. 6, at Akron.—Bulletin.

### TRUMBULL

Officers of the Trumbull County Medical Society for 1945 are: Dr. David L. Beers, Warren, pres.; Dr. E. L. McDougall, Warren, vice-pres.; Dr. E. G. Caskey, Mineral Ridge, secy.-treas.; Dr. M. T. Knappenberger, Warren, chmn., Legislative Committee; Dr. Paul Gauchat, chmn., Committee on War Participation; Dr. Henry J. Meister, Warren, chmn., Committee on Industrial Health; Dr. H. W. Law, Champion Heights, chmn., Committee on Recreation and Physical Fitness.

## Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

### BELMONT

The Belmont County Medical Society has re-elected the following officers for 1945: Dr. C. W.

Lose, Flushing, pres.; Dr. J. B. Martin, St. Clairsville, pres.-elect; Dr. C. W. Kirkland, Bellaire, secy.-treas.; Dr. R. H. Wilson, Martins Ferry, chmn., Legislative Committee; Dr. F. P. Sutherland, Martins Ferry, chmn., Committee on War Participation; Dr. H. E. Ring, Bellaire, chmn., Committee on Industrial Health.

### CARROLL

Dr. Ralph L. Rutledge, Alliance, Councilor for the Sixth District, was guest speaker at a joint meeting and dinner party of the Carroll County Medical Society and its Woman's Auxiliary, Jan. 10, at the Elks Home, Alliance.

### JEFFERSON

The following Steubenville physicians are officers of the Jefferson County Medical Society for 1945: Dr. John Y. Bevan, pres.; Dr. J. Ellison Gamble, vice-pres.; Dr. S. A. Harris, secy.-treas.; Dr. E. J. C. Sander, chmn., Legislative Committee.

### TUSCARAWAS

At a meeting of the Tuscarawas County Medical Society, Dec. 14, at Dover, the following officers were elected for 1945: Dr. B. O. Burkey, Baltic, pres.; Dr. E. C. Davis, Dover, vice-pres.; Dr. C. J. Miller, New Philadelphia, secy.-treas.; Dr. Jay W. Calhoon, Uhrichsville, chmn., Legislative Committee.

Dr. John E. Briggs, Columbus, spoke on "Thyroid Disturbances", at a meeting of the society, Jan. 10, at the Hotel Reeves, New Philadelphia. It was a dinner meeting, with members of the Woman's Auxiliary as guests.

The program for a meeting of the society, Feb. 7, at the City Building, New Philadelphia, was given by Dr. R. J. Foster, New Philadelphia, who presented three groups of interesting case histories illustrating the cases by X-rays. The cases consisted of three interesting bone cases, four unusual massive gastric hemorrhage cases, and three cases of tumor mass in the upper abdomen which was relieved by individual surgery in each case. There was much beneficial discussion of these various cases. There were 14 members present.—C. J. Miller, M.D., secretary.

## Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

### ATHENS

"Penicillin", was the subject of a talk made by Dr. L. D. Robinson, Guysville, at a meeting of the Athens County Medical Society, Jan. 11, at the Hotel Berry, Athens.—News clipping.

### LICKING

Officers of the Licking County Medical Society for 1945 are: Dr. Wm. Allen Avery, Alexandria, pres.; Dr. Arthur J. Tronstein, Newark, vice-pres.; Dr. R. G. Plummer, Newark, secy.-treas.; Dr. John R. McClure, Newark, chmn., Legislative



Committee; Dr. Plummer, chmn., Committee on War Participation; Dr. H. A. Campbell, Newark, chmn., Committee on Industrial Health; Dr. Clarence G. Bozman, Newark, chmn., Committee on Recreation and Physical Fitness.

#### MORGAN

The Morgan County Medical Society has elected the following officers for 1945: Dr. Galen Rex, McConnellsville, pres.; Dr. A. H. Whitacre, Chesterhill, vice-pres.; Dr. C. E. Northrup, McConnellsville, secy.-treas., and chmn., Legislative Committee.

#### MUSKINGUM

Dr. Charles F. Bowen, Columbus, spoke on "Treatment of Malignancies", at a meeting of the Muskingum County Academy of Medicine, Feb. 7, at Zanesville.

Officers of the society for 1945 are: Dr. H. T. Glaser, Zanesville, pres.; Dr. D. K. Matthews, Dresden, vice-pres.; Dr. Beatrice T. Hagen, Zanesville, secy.-treas.; Dr. R. S. Martin, Zanesville, chmn., Legislative Committee; Dr. Fred W. Phillips, Zanesville, chmn., Committee on War Participation; Dr. D. G. Caudy, Zanesville, chmn., Committee on Industrial Health; Dr. George C. Malley, Zanesville, chmn., Committee on Recreation and Physical Fitness.

#### PERRY

At a meeting of the Perry County Medical Society, Jan. 25, at the Park Hotel, New Lexington, the following officers were elected for the ensuing year: Dr. Wm. D. Porterfield, Junction City, pres.; Dr. James Miller, Corning, vice-pres.; Dr. H. F. Minshull, New Lexington, secy.-treas.; Dr. James Miller, chmn., Legislative Committee and the Committee on War Participation; Dr. Robert Miller, Hemlock, chmn., Committee on Industrial Health and the Committee on Recreation and Physical Fitness.

### Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

#### HOCKING

The following Logan physicians are officers of the Hocking County Medical Society for 1945: Dr. H. G. Southard, pres.; Dr. C. F. Shonk, vice-pres.; Dr. M. H. Cherrington, secy.-treas.; Dr. J. S. Cherrington, chmn., Legislative Committee.

#### LAWRENCE

The Lawrence County Medical Society entertained the nurses and nurses aides of Ironton at a dinner, Jan. 18, at the Hotel Marting, Ironton. The dinner was given for the nurses by the society in appreciation of their loyal service during the shortage of nurses. The guest speaker, Dr. John Brandabur, Huntington, W. V., gave an address on "Nursing As An Adventure".—H. S. Allen, M.D., president.

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### MEIGS

Officers of the Meigs County Medical Society for 1945 are: Dr. R. E. Boice, Middleport, pres.; Dr. P. A. Jividen, Rutland, vice-pres., and chmn., Legislative Committee; Dr. F. M. Cluff, Middleport, secy.-treas., and chmn., Committee on Industrial Health.

### SCIOTO

Dr. Robert E. S. Young, Columbus, spoke on "Medical Service Plans", at a meeting of the Hempstead Academy of Medicine, Jan. 15, in the auditorium of the Nurses' Home, Portsmouth General Hospital.

"Current Trends in the Early Diagnosis and Management of Cancer", was the subject discussed by Dr. Jay McLean, Columbus, at a meeting of the Academy, Feb. 12, at Portsmouth. A colored film on "Treatment of War Injuries", was also shown.—T. W. Frame, M.D., secretary.

### Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

#### FRANKLIN

The following programs were presented by the Columbus Academy of Medicine during February:

**Feb. 5**—"Penicillin in Venereal Disease", Dr. Roger E. Heering, State Director of Health; discussant, Dr. L. J. Roth.

**Feb. 19**—"Medical Service Plans", Dr. Robert E. S. Young; discussants, Dr. Jonathan Forman and Dr. Charles W. Pavay.—Bulletin.

Officers of the Academy for 1945 are: Dr. George J. Heer, pres.; Dr. Horace B. Davidson, pres.-elect; Dr. John A. Prior, secy.-treas.; Dr. John M. Thomas, chmn., Legislative Committee; Dr. Robin C. Obetz, chmn., Committee on War Participation; Dr. Frank A. Riebel, chmn., Committee on Industrial Health.—Stanley R. Mauck, executive secretary.

#### MORROW

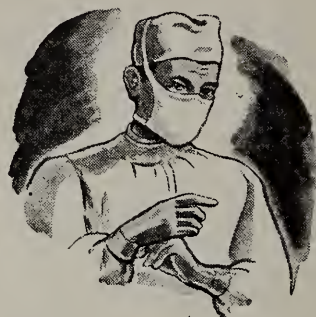
Officers of the Morrow County Medical Society for 1945 are: Dr. Frank M. Hartsook, Cardington, pres.; Dr. C. S. Jackson, Mt. Gilead, vice-pres.; Dr. T. H. Sweeney, Mt. Gilead, secy.-treas.; Dr. Wm. L. Murphy, Cardington, chmn., Legislative Committee; Dr. W. E. DeVol, Marengo, chmn., Committee on War Participation; Dr. Jos. P. Ingmire, Mt. Gilead, chmn., Committee on Industrial Health; Dr. E. C. Sherman, Cardington, chmn., Committee on Recreation and Physical Fitness.

#### PICKAWAY

Officers of the Pickaway County Medical Society for 1945 are the following Circleville physicians: Dr. D. V. Courtright, pres.; Maj. E. L. Montgomery, M. C., vice-pres.; Dr. Walter F. Heine, secy.-treas.; Dr. G. W. Heffner, chmn., Legislative Committee.



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ROSS

Dr. Gordon F. McKim, professor of urology, University of Cincinnati College of Medicine, spoke on "Diagnosis and Treatment of Tuberculosis of the Kidneys", at a meeting of the Ross County Academy of Medicine, Jan. 4, at Chillicothe.—News clipping.

UNION

The Union County Medical Society has elected the following officers for 1945: Dr. Angus MacIvor, Marysville, pres.; Dr. B. E. Ingmire, Plain City, vice-pres.; Dr. James M. Snider, Marysville, secy.-treas.; Dr. F. C. Callaway, Marysville, chmn., Legislative Committee; Dr. F. M. Wurtsbaugh, Richwood, chmn., Committee on War Participation and Committee on Recreation and Physical Fitness; Dr. MacIvor, chmn., Committee on Industrial Health.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ERIE

The following Sandusky physicians are officers of the Erie County Medical Society for 1945: Dr. Wm. F. Burger, pres.; Dr. Wm. T. Fenker, vice-pres.; Dr. E. J. Meckstroth, secy.-treas.; Dr. Ross M. Knoble, chmn., Legislative Committee; Dr. A. R. Grierson, chmn., Committee on War Participation; Dr. Paul N. Squire, chmn., Committee on Industrial Health.

LORAIN

Rollen W. Waterson, Gary, Ind., executive secretary of the Lake County Medical Society and the Association of American Physicians and Surgeons, was guest speaker at a meeting of the Lorain County Medical Society, Feb. 13, at Lorain.—L. H. Trufant, M. D., secretary.

Officers of the society for 1945 are: Dr. Stanley J. Birkbeck, Elyria, pres.; Dr. Myron Kishman, Lorain, vice-pres.; Dr. L. H. Trufant, Oberlin, secy.-treas.; Dr. Swen D. Nielsen, Elyria, chmn., Legislative Committee; Dr. Paul Tillman, Elyria, chmn., Committee on War Participation; Dr. Geo. Blank, Lorain, chmn., Committee on Industrial Health; Dr. John Nichols, Oberlin, chmn., Committee on Recreation and Physical Fitness.

MEDINA

Officers of the Medina County Medical Society for 1945 are: Dr. R. F. Fasoli, Brunswick, pres.; Dr. Robert Rowe, Medina, vice-pres.; Dr. E. C. Bell, Lodi, secy.-treas.; Dr. Fasoli, chmn., Legislative Committee; Dr. R. L. Mansell, Medina, chmn., Committee on War Participation; Dr. Harry Street, Litchfield, chmn., Committee on Industrial Health.

Hilliards—Dr. J. W. Reason is the new president of the Franklin County Board of Education. Dr. J. C. Sommer, Grove City, is a new member of the Board.

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## WOMAN'S AUXILIARY NEWS

(By MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### FRANKLIN

A two-part discussion program on child health was presented at the January meeting of the Woman's Auxiliary to the Columbus Academy of Medicine.

Dr. Ruth St. John acted as moderator for the discussion on "Health Examinations for School Children and Employes", and "The Kellogg School Education Plan". Mr. O. E. Hill, superintendent of Upper Arlington schools, Dr. Myron Miller and Mrs. Florence L. Fogle discussed health examinations for school children and employes. The Kellogg School Education plan constituted the second part of the program with the following participants: Mr. Paul Landis, state department of education; Miss Gertrude Bush, chief, nursing division; and Miss Elsie Gottshall, co-ordinator, school health project. Each speaker was allotted six minutes for each topic, after which the meeting was open for questions and discussion.

### HARRISON

The Woman's Auxiliary to the Harrison County Medical Society meets on the third Wednesday of each month, at the same time and place as the medical society. The Auxiliary has offered its services to Fletcher Hospital. Mrs. E. L. Miller read an interesting paper at the Bowerston Woman's Club on the "Dangers of Socialized Medicine".

### KNOX

The Woman's Auxiliary to the Knox County Medical Society has organized two guilds for each of the local hospitals, meeting once a week on alternate weeks. Mrs. Julius Shamansky is general chairman of this project. The purpose of the guilds is to sew garments and do mending for the hospitals. The regular auxiliary meeting was held Feb. 7 at the home of Mrs. James F. Lee, Mt. Vernon, with Mrs. Robert Eastman as co-hostess. During the business meeting Mrs. Shamansky reported that the guilds had contributed 318 hours of service to sewing and mending.

### MARION

Officers were re-elected at the January meeting of the Woman's Auxiliary to the Marion County Academy of Medicine, when they met for luncheon at the Hotel Harding, Marion. The re-elected board includes: Mrs. J. A. Dodd, pres.; Mrs. Carl W. Sawyer, vice-pres.; Mrs. Richard Morgan, recording secy.; Mrs. Frederick Merchant, cor. secy.; and Mrs. C. G. Smith, treas. Plans were made to buy a new Hess infant incubator and bed with oxygen therapy unit. Mrs. E. H. Morgan was appointed to represent the auxiliary as the maintenance chairman of

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the cancer clinic committee. Interesting talks of experiences of medical men in service were given by their wives and mothers.

**RICHLAND**

The January meeting of the Woman's Auxiliary to the Richland County Medical Society was held at the home of Mrs. D. A. Weir, Mansfield, with Mrs. W. E. Wygant as associate hostess. Mrs. Charles Brown reported that members had contributed 781 hours to the Red Cross for making surgical dressings during 1944. Bridge was the diversion of the afternoon, with Mrs. C. R. Damron and Mrs. Brown winning high score prizes.

The Auxiliary to the County Medical Society met Feb. 5 at the Women's Club, Mansfield, with Mrs. Charles Brown and Mrs. John Clark as hostesses. Mrs. Leopold Adams, vice-pres., conducted the business meeting during which letters from doctors serving overseas were read. Members voted to contribute to the infantile paralysis fund. High score for the bridge session was won by Mrs. J. L. Stevens.

**ROSS**

The Woman's Auxiliary to the Ross County Academy of Medicine, Chillicothe, met Thursday evening, February 1, with the president, Mrs. Walter Breth, presiding. There were twelve members and two guests present. Mr. Martin Schaffer was the guest speaker, and discussed "The Veteran Comes Home". Mrs. M. D. Scholl gave a report on the card parties given by the members to raise funds for an incubator to be purchased for the Chillicothe Hospital.

**SUMMIT**

Under the leadership of Mrs. V. C. Malloy, Akron, '17 registered nurses in the auxiliary serve regularly at the Red Cross Blood Donor Service, four being on duty each day. Mrs. Malloy has recently been elected on the Board of Summit County Red Cross Home Nursing. Members of the auxiliary have contributed many hours of service assisting in the four Akron hospitals,

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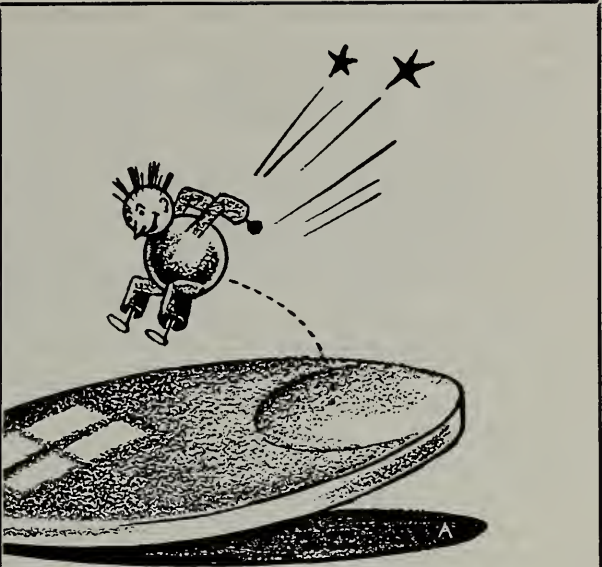
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A resume of the meetings and programs follows: Meetings are held in the Idabelle Firestone Nurses' Home, Akron, the first Tuesday of each month, at 8:00 P.M., which is the same night the Summit County Medical Society meets, the auxiliary members joining their husbands later for refreshments. Mrs. D. M. McDonald is president and has been responsible for the many interesting programs. Mrs. John D. Brumbaugh provided an interesting motion picture portraying her trip to Alaska. Another outstanding meeting was held jointly with the Medical Society, the guest speaker being Dr. F. M. Barry, of the department of surgery, University Hospital, Cleveland. Following the talk a buffet supper was served in honor of Dr. Barry. At the November luncheon fifty members were present to hear Mrs. Roswell W. Fidler, Columbus, President of the State Auxiliary, give an interesting and instructive talk. A highlight of the January meeting was an informal talk by Commander William McK. Johnston, a member of the Summit County Medical Society recently released from active duty with the Navy Medical Corps. He had the distinction of having participated actively in service in combat areas. The party planned in honor of the wives of physicians in the service had to be postponed due to weather conditions.

#### TUSCARAWAS

Officers of the Woman's Auxiliary to the Tuscarawas County Medical Society for 1945 are: Mrs. J. W. Calhoon, Uhrichsville, pres.; Mrs. V. C. Nipple, Midvale, vice-pres.; Mrs. W. W. H. Curtiss, Dennison, secy-treas.; and Mrs. Paul Hirsch, Bolivar, pres.-elect for 1946. At a meeting held at Hotel Reeves in January, a summary of the year's activities was given by Mrs. F. C. Yeager, of Dover, retiring secretary. She reported that during the year subscriptions to *Hygeia* magazine had been sent to every high school in the county, as well as to the County Children's Home, Tuberculosis Sanatorium, and the Youth Centers in Dover, Dennison and Uhrichsville. Reports of the year's projects revealed that musical recordings had been sent to the Primrose school for crippled children; that \$50.00 had been donated to Union Hospital and Twin City Hospital for robes. Christmas fruit cakes were sent to doctors in the service, eight

dozen popcorn balls were sent to the Children's Home at Christmas, and a \$10.00 Christmas donation to the Dennison Canteen. Mrs. J. E. Briggs, Columbus, and Mrs. E. L. Miller, Bow-erston, president of the Harrison County Auxiliary, were guests.

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## Blue Cross and 21 Medical Plans Are Now Co-ordinated

Plans whereby Americans can budget their doctor bills as they do their hospital bills continue to develop in number and in area covered both in the United States and Canada.

Twenty-one medical prepayment plans, sponsored by state and county medical societies and available through Blue Cross hospital service plans, are now serving the residents of that many states and regions.

Six months ago, only 15 such plans were in operation. Since then, newly formed non-profit medical plans have begun enrolling members in the states of Nebraska and New Hampshire and in the area of Huntington, W. Va.

Three other recently launched medical plans, Missouri Medical Service, Virginia Medical Service, and Central New York Medical Plan, Inc., expect to make membership available to state residents by February 1.

Manitoba Medical Service (Canada) has announced provision of both medical and surgical protection for employed groups and their dependents. Public desire, however, is greatest for surgical bill protection since it is less predictable and therefore more difficult to budget.

In the United States, most medical plans restrict themselves to paying only for those doctor bills incurred during hospitalized illness or injury. As in Canada, the residents of the United States seem to prefer this type of protection.

Medical societies in Ohio, Indiana, Oklahoma, Kansas and Iowa are working in close co-operation with Blue Cross plans to develop medical and surgical prepayment plans for residents of these states. At a recent regional meeting in St. Paul, doctors from Minnesota, North Dakota, South Dakota, and Wisconsin expressed their interest in forming medical plans.

In fact, it would be difficult to find a state in which a plan has not been formed or in which the medical profession is not considering plan formation. Should the present trend of growth of medical plans continue, soon the same 95 per cent of the American people who can obtain Blue Cross hospitalization can also secure doctor bill protection on a non-profit voluntary basis.—*Blue Cross Protection*, quarterly magazine of Blue Cross Plans.

Columbus—Dr. Donald F. Bowers has been re-elected president of the Buckeye Republican Club.

Youngstown—"Allergy, Its Concepts and Manifestations", was the topic discussed by Dr. S. R. Zoss at a meeting of the Mercer County Medical Society, Greenville, Pa.

Akron—Quarters in the basement of the new medical building at City Hospital include new nurses' and doctors' dining rooms, and a billiard room.

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### Annual Meeting of Cleveland Medical Library Association

At its 50th annual meeting in the Allen Memorial Library, Jan. 19, the Cleveland Medical Library Association re-elected Dr. Howard Dittrick, president, and Dr. Lawrence A. Pomeroy, chairman of the board of trustees.

Dr. J. A. Garvin was elected secretary and Dr. C. W. Wyckoff, treasurer. Directors named were: Dr. H. N. Cole, finance; Dr. R. M. Stecher, library; Dr. M. P. Motto, membership; Dr. Harold Feil, program; Dr. Louis Karnosh, publications; Dr. Dittrick, museum, and Dr. C. G. La Rocco, maintenance.

Drs. R. L. Haden, H. D. Piercy, R. M. Stecher, M. P. Motto and C. W. Wyckoff were named to the board of trustees.

The constitution was amended to entitle members who have contributed a total of \$1,000 or more, exclusive of annual membership dues, to life membership.

Dr. Clyde L. Cummer, who reviewed the achievements of the association's semi-centennial celebration, highlighted by a jubilee dinner last November, told the meeting the prime purpose of observing the semi-centennial had been a constructive one—to secure additions to the association's rare and old book collection, enlarge the museum collection and to increase the endowment fund.

### Tuberculosis Hospital Named In Honor of Dr. Kennon Dunham

"Dunham Hospital", is the new name of the Hamilton County Tuberculosis Hospital, by a recent action of its Board of Trustees, in honor of the late Dr. H. Kennon Dunham, who had a notable career in the field of tuberculosis. He served as medical director of the Hamilton County Tuberculosis Hospital from 1914 to 1941 and served in the Medical Corps of the U.S. Army, World War I, as captain and major. Dr. Dunham served on the Medical Council of the American Legion for many years and was always concerned with the problem of tuberculosis in veterans. After Dr. Dunham's resignation as medical director of the Hamilton County Tuberculosis Hospital he was appointed a member of the Board of Trustees and remained a member until his death on April 27, 1944.

Lebanon—Rounding out 25 years as health commissioner of Warren County, Dr. Edward Blair was recently reappointed for an additional two-year term.

Ashland—The War Production Board has authorized the construction of a \$150,000 addition to Samaritan Hospital. The new wing will provide a contagious ward and additional facilities for surgical and obstetrical patients.

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### Gifts Made to Medical College

Recent gifts to the University of Cincinnati College of Medicine include the following: \$10,000 to the Christian R. Holmes Hospital from the Holmes Foundation, Inc.; \$7,500 over three years from the Nutrition Foundation, Inc., for research directed by Dr. Josef Warkany, assistant professor of pediatrics; \$17,250 from six contributors for research directed by Dr. Tom D. Spies, associate professor of medicine; and \$5,000 from Mrs. David May, to the College of Medicine May Fund.

Dr. Edward King was named acting director of the laryngology service at General Hospital, and Dr. Henry M. Goodyear acting director of the otology service. Dr. John H. Skavlem was renamed director of the Tuberculosis Hospital, and Dr. Hiram B. Weiss, director of the medical service at the Chronic Disease Hospital.

### New Rheumatic Fever Film

"Jimmy Beats Rheumatic Fever", a 15-minute sound film strip, has just been released by the Metropolitan Life Insurance Company. The strip was made under the supervision of George M. Wheatley, M.D., assistant medical director of the company. Officials of the New York City Department of Health and the Board of Education are recommending it for training courses for nurses and teachers as well as for mothers' clubs. The strip was produced primarily for parents, teachers and others who work with children. It is an eight-year old boy's story about his successful battle with rheumatic fever. It is not a motion picture, but a single-frame 35 mm. film strip with a 16-inch record. Other material which will help in rounding out a program on rheumatic fever is available from the company. Requests for this and the strip should be addressed to Welfare Division, Metropolitan Life Insurance Company.

**Youngstown**—Staff officers of St. Elizabeth Hospital are the following: Dr. F. W. McNamara, chief; Dr. E. H. Nagel, vice-chief; Dr. Saul J. Tamarkin, secy-treas.; Dr. R. B. Poling, director of medicine; Dr. J. M. Ranz, director of surgery; Dr. A. J. Brandt, director of obstetrics and gynecology; Dr. J. B. Birch, additional member of the executive committee. Dr. C. D. Hauser was elected staff representative to Associated Hospital Service, Inc.

**Mansfield**—The importance of developing community plans for the treatment of venereal disease was emphasized by Dr. W. E. Wygant in a talk before the Rotary Club.

**Bedford**—Dr. Edith Petrie Brown gave an address on "A Woman Faces Fifty", at a meeting of the Warner P.T.A.

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# Do You Know - - -

Ralph Locher, Shaker Heights attorney, has been appointed secretary of the State Industrial Commission. He succeeds Ralph Klapp, Columbus, who resigned to become an assistant attorney general.

\* \* \*

Ohio State University College of Medicine will receive \$20,000 from the estate of the late Werner Strang, Columbus builder, for the establishment of the "Werner Strang and Asta K. Strang Foundation for Cancer Research".

\* \* \*

Dr. A. D. Cook, a practicing physician in Dayton for the past 17 years, has first-hand knowledge of the Philippines. Shortly after World War I he was medical director for the American Mindoro Sugar Company. Altogether he spent 10 years in the Orient, and at one time was superintendent of St. Luke Hospital in Manila.

\* \* \*

Now in his 58th year of medical practice, Dr. J. V. Winans, Madison, recently delivered the great-grandchild of his first obstetrical patient.

\* \* \*

The American people in 1944 contributed almost \$23,000,000 in cash and goods to Russian War Relief, making a total of \$46,246,240 received by this agency since its inception a little over three years ago. Clothing, medical and surgical supplies, household kits, seeds and miscellaneous relief items valued at \$14,675,839.81 were contributed to the agency direct and \$8,091,272.90 in cash was contributed through the National War Fund.

\* \* \*

Dr. Jonathan Forman, Columbus, was one of the sponsors of The School for Living Institute conducted by Ralph Borsodi, noted economist, lecturer and author, at Chicago, during the week of Feb. 12.

\* \* \*

The death rate from tuberculosis in the United States has been cut nearly in half in the past 20 years. In 1943 approximately 56,000 persons died of the disease, compared with 110,285 in 1923. Deaths from tuberculosis in Ohio during 1943 totaled 2,780, a death rate of 39.76 per 100,000 of population.

\* \* \*

The present paper shortage is reflected in a decrease in the number of books on medicine and hygiene published in 1944. There were 197 new books and 76 new editions, a total of 273, during the year. In 1943 there were 244 new books and 107 new editions published, a total of 351. This is a net loss of 58 books.

There were 17 deaths attributed directly to football during 1944, one of them the first college football fatality since 1940, according to a news dispatch. Five deaths were among players on sand lot teams, two on athletic club teams and nine in high school. The most frequent cause of death was cerebral hemorrhage.

\* \* \*

The address entitled: "Medical Attitudes, Opportunities and Responsibilities in a National Fitness Program", given by Dr. John W. Wilce, at the Annual Conference of Secretaries and Editors of Constituent State Medical Associations, Nov. 18, 1944, at Chicago, was published in the Jan. 27 issue of the *J.A.M.A.* Head of the Student Health Service at Ohio State University, Dr. Wilce is a member of the National Committee on Physical Fitness.

\* \* \*

A research project to determine whether a Russian-developed serum with widely claimed curative powers is effective against cancer is being conducted at the Institute of Pathology of Western Reserve University, under the supervision of Dr. Harry Goldblatt, associate director of the institute.

\* \* \*

R. P. Knerr, director of the biological laboratories of The National Drug Company, was informed recently by Under Secretary of War, Robert P. Patterson, that the plant had been awarded the Army-Navy "E" for excellence in war production.

\* \* \*

Dr. A. D. Blackburn, Circleville, health commissioner of Pickaway County, has been elected vice-president of the United Roller Club of America, an organization which promotes interest in Roller pigeons. Dr. Blackburn, whose hobby is raising Roller pigeons, has been a director of the national organization for two years.

\* \* \*

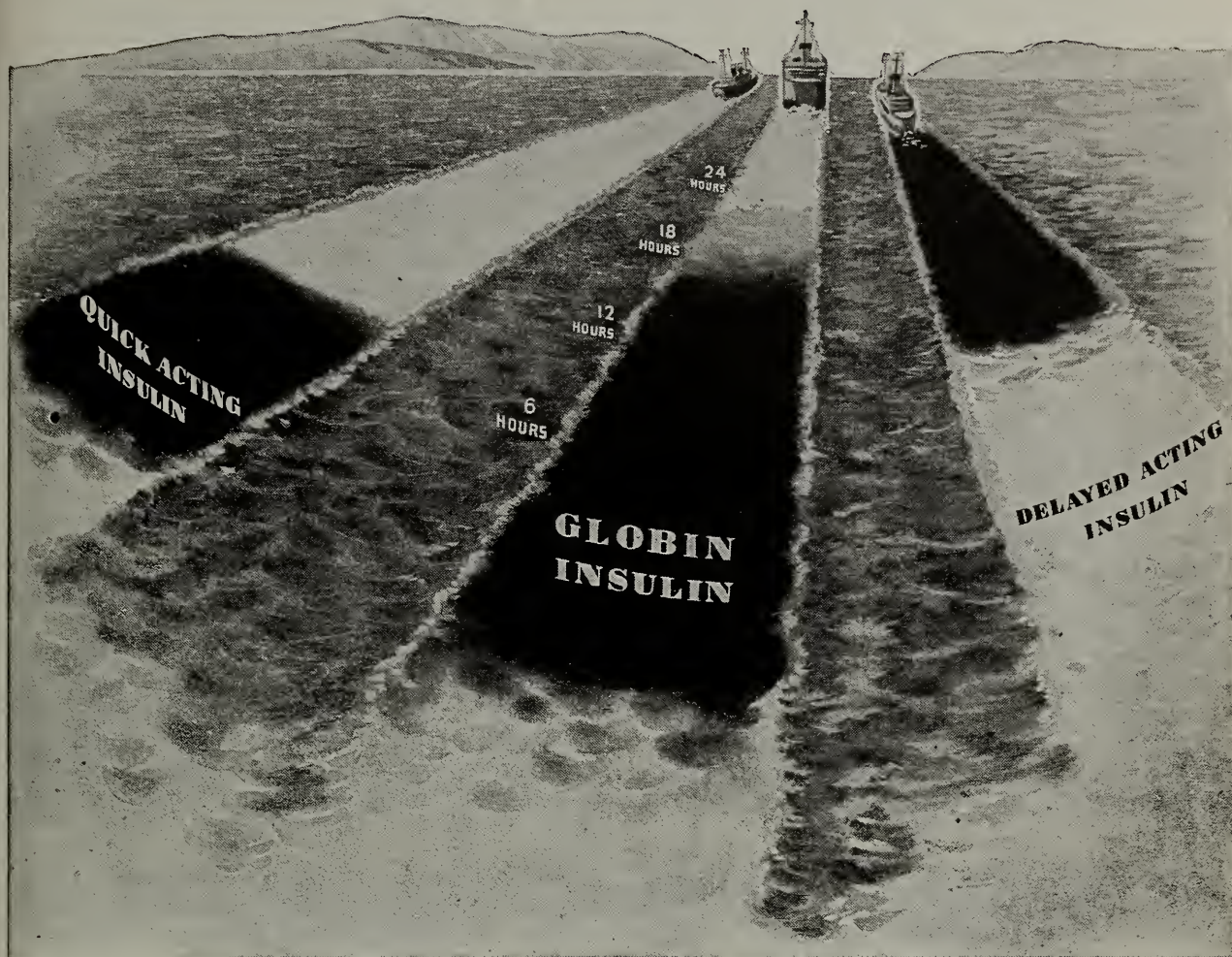
The Mahoning County Medical Society presents a radio program over Station WKBN, Youngstown, every Saturday at 11:30 A.M.

\* \* \*

The State Industrial Commission has refused to make payments from its catastrophe fund to dependents of East Ohio Gas Co. employees killed in the Oct. 20 Cleveland fire, and directed the utility, a self-insurer to settle the claims. Seventy-three East Ohio workers were killed. The company contended it came under regulations of the commission for disaster payments from state funds providing a maximum of \$7,000 plus \$200 burial expenses for each victim.



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## The Physician's Bookshelf

**Patients Have Families**, by Henry B. Richardson, M.D. (\$3.00. *The Commonwealth Fund, New York City*) is a much needed book for the staffs of large hospitals. For about the only signs showing to them, that patients do have families, are the occasional baby carriages parked outside the entrance or the long line of relatives waiting for the elevators at the start of visiting hours. The author points out that the physician learns the importance of the family in the patient's illness, much as they have had to relearn the psychosomatic medicine of their professional ancestors. This work will prove helpful to all who come in contact with the sick.

**A Scientific Theory of Culture and Other Essays**, by Bronislaw Malinowski. (\$3.00. *The University of North Carolina Press*) is a statement of the author's theory of functionalism, a theory that has become one of the storm centers of modern anthropology. In brief, the author insists that culture is an adjustment of human needs and desires. This essay had just been completed at the time of the author's death. Included in the volume are two other heretofore unpublished works: "The Functional Theory" and "Sir James George Frazer". To all physicians who are interested **Culture and Man as a Social Being**, this book will prove most interesting.

**Missionary Doctor**, by Mary Floyd Cushman, M.D., (\$2.75. *Harper & Brothers, New York City*) is the study of the author's 20 years in Africa. What makes her story different is that, after a successful career in medicine in Maine at the age of 53, she decided to do what she always wanted to do and went out as a missionary in Angola, Portugese, West Africa. The doctor tells a most interesting story.

**Internes Handbook**, by the Members of the Faculty of the College of Medicine of Syracuse University (\$3.00. 3rd Ed. *J. B. Lippincott Co., Philadelphia*) has been brought up to date for the job which its title indicates.

**Fischerisms**, edited by Howard Fabing, M.D., and Ray Marr, M.D., (not for public sale, designed as a private print for Martin Fischer's students. *Charles C. Thomas, Springfield, Ill.*) is a third and enlarged edition reflecting the brilliance of that great teacher, beloved by all Ohio physicians.

**New and Nonofficial Remedies, 1944**, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association. (\$1.50. *A.M.A., Chicago*) reflects two important

and forward looking decisions of the Council, namely to use the metric system exclusively in all of its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians.

**Personal Mental Hygiene**, by Dom Thomas V. Moore, M.D., (\$4.00. *Grune & Stratton, Inc., New York City*) is primarily intended for the individual. The author, a doctor, of medicine and of philosophy, as well as an ordained priest and professor of psychology and psychiatry in the Catholic University of America, places more than the usual emphasis upon ideals and principles as a means to give stability to the personality, which is as it should be. Alcoholics Anonymous has taught us "heathens" that treating mental disturbances on an emotional basis alone is not enough. So it seems logical, therefore, to bring into psychiatry the higher things in human life.

**Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1944.** (\$1.00. *A.M.A., Chicago*) contains only eight reports on rejected articles; it is interesting to note that even the objections to these are on a much higher plane than those it was necessary to urge against the flagrantly quackish preparations of the charlatans of our student days. The world does move.

**Re-education in a Nursery Group.** A study in Clinical Psychology by Ruth Wendell Washburn (\$2.00. *Monograph of the Society for Research in Child Development, Vol. IX, No. 2, Serial No. 38*) is the account of the work the Nursery Group at the Clinic of Child Development at Yale University.

**Soldier to Civilian—Problems of Readjustment**, by George K. Pratt, M.D., (\$2.50. *Whittlesey House, New York City*) is done by an authority who writes a very helpful volume which will aid in solving one of the profound headaches that goes with the coming peace.

**The Marihuana Problem in the City of New York**, by the Mayor's Committee on Marihuana (\$2.50. *The Jacques Cattell Press, Lancaster, Pa.*) presents the results of an informative survey. Clinical experimental study is also reported.

**The Abortion Problem** (*The Williams & Wilkins Co., Lawrence, Ind.*) is the proceedings of the conference held under the auspices of the National Committee on Maternal Health, Inc., at the New York Academy of Medicine in June, 1942. Competent authorities discuss the magnitude of the problem, its social, moral and economic causes, as well as its control.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

April, 1945

No. 4

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## Circulatory Failure During Anesthesia

B. B. SANKEY, M.D.

WITH the increased popularity of intravenous fluid therapy as a supportive measure, the incidence of profound circulatory depression during surgical procedures has been greatly reduced. Modern methods of anesthesia have extended the range of successful surgery to include an increasing number of poor risk patients. Certainly it is the anesthesiologist's duty to provide anesthesia expertly and skilfully, and with a minimum disturbance to normal physiological processes, if the best interests of the patient are to be served. This should apply not only to poor risk patients but to all patients subjected to anesthesia.

### CONTRIBUTING FACTORS

Some of the factors that contribute to circulatory depression in patients undergoing surgery include trauma, hemorrhage, position of patient on operating table, physical state of patient, and the anesthesia. Trauma in some surgical procedures results in considerable depression. Operations on the bones, viscera and brain are considered to be relatively high in traumatic value.<sup>6</sup> Trauma from the site of operation usually causes a gradual change in the state of the circulation, and one usually has enough warning that preparations may be made to support the circulation before it reaches a critical level.

When hemorrhage is encountered the severity of the symptoms depends not only on the extent of the hemorrhage but on the physical condition of the patient. Guodel<sup>1</sup> states that even a small hemorrhage may prove fatal in the presence of coronary artery disease. When the blood pressure falls so low that the heart is not oxygenated,

### The Author

● Dr. Sankey, Cleveland, Ohio, is a graduate of Hahnemann Medical College, Philadelphia, 1933; diplomate, American Board of Anesthesiology; member, Internal Anesthesia Research Society and American Society of Anesthetists; head, Dept. of Anesthesia, St. Luke's Hospital, Cleveland.

cardiac anoxia occurs with impairment of function, resulting in ineffectual contractions of the heart. Death may then quickly ensue. In combating the effects of hemorrhage, the anesthesiologist's attention should be directed to the administration of a high concentration of oxygen and to the support of the blood pressure as near normal as possible with the use of intravenous fluids. Severe blood loss should be replaced by whole blood whenever possible.

Certain surgical procedures require that the patient be placed in positions that tend to embarrass respiration and circulation. Since respiration and circulation go hand in hand and are interdependent, the embarrassment of one system leads quickly to depression in the other. The lateral position, utilized for kidney operations, with elevation of the bridge, is not tolerated well by many individuals. In this position both respiration and circulation are considerably embarrassed. Use of the gall bladder bridge tends to cause considerable depression, as does also the severe Trendelenberg position and the prone position.

The physical state of the patient many times contributes to the extent of circulatory depression. Poor risk patients, and especially those suffering from decreased functional capacity of

<sup>6</sup> Presented at the Annual Meeting of the Ohio Society of Anesthetists, held in conjunction with the Ninety-Eighth Annual Meeting, Ohio State Medical Association, Columbus, May 3, 1944.

the heart, are especially prone to develop circulatory depression in the operating room.

#### ANESTHESIA AS A FACTOR

The last factor, and by no means the least important, in contributing to circulatory depression is the anesthesia itself. Patients do not tolerate deep anesthesia well for extended periods. When profound relaxation is required, as for certain long upper abdominal procedures, it is frequently possible to produce excellent relaxation by using combinations of several agents or methods with a minimum disturbance of circulation.

Lundy<sup>2</sup> has long been an advocate of using combinations of agents and methods. The desired result is often accomplished with less disturbance to patients than when large or toxic doses of a single anesthetic agent are employed. Potter<sup>3</sup> has reported on the advantages of the combination of spinal anesthesia and cyclopropane in producing anesthesia for upper abdominal procedures. He pointed out that a lower dosage of a spinal anesthetic drug was required when the patients were intentionally supplemented with a light plane of cyclopropane anesthesia than when using spinal anesthesia alone. It is still my impression that a safer anesthesia may be provided in many situations by using combinations of agents and methods rather than using a large dose of a single anesthetic.

It has frequently been stated that it is much easier to prevent shock than to treat it. Severe progressive circulatory depression may often be avoided in the operating room by the judicious use of intravenous fluids before a profound degree of depression has occurred. It has proven good practice to routinely start intravenous fluids on all patients undergoing upper abdominal surgery or other surgery where a profound degree of relaxation is required for extended periods. The speed or rate of flow of fluids may be adjusted to meet the needs of the individual case. It is advisable to use a large bore needle so that plasma or blood may be administered through the same needle if the need arises.

According to Coller,<sup>4</sup> the indiscriminate use of saline solutions should be avoided and for all around usefulness a solution of 5 per cent dextrose in water has proven most satisfactory. If one delays administering fluids until the blood pressure has reached a critical level, considerable difficulty is often encountered in attempting venipuncture. In the best interests of the patient one should avoid this state of affairs if possible, and this can best be accomplished by instituting fluid therapy while the circulation is still reasonably good.

Anesthetists are constantly dealing with altered and normal physiology of the respiratory and circulatory systems. When resuscitative pro-

cedures are required the anesthetist is often the most logical member of the operating team to direct proper restorative measures. Burnbaum and Thompson<sup>5</sup> have called attention to the necessity of prompt institution of resuscitative procedures, if a successful outcome is to be accomplished. Attention should be directed toward supplying a high concentration of oxygen to the lungs and circulation so that the heart muscle and brain tissue in particular may be efficiently oxygenated.

Hamilton Bailey<sup>6</sup> has re-emphasized the value of cardiac massage for impending death. He points out that if one is to successfully treat patients who are in a profound state of circulatory depression in the operating room, one must have a preconceived plan of action in mind, and when disaster strikes this plan should be put into immediate operation. The prompt institution of a well-planned program is one of the most important factors of the successful management of circulatory failure.

In other words the time is limited during which one has a reasonable chance of obtaining a successful result from resuscitation.

#### ROUTINE PROGRAM

The following program for resuscitation in the operating room has proven worth while. (1) Inflate the patient with 100 per cent oxygen after emptying the contents of the breathing bag. Repeated emptying of the bag will be required to wash out the anesthesia mixture from the patient. (2) Lower the patient's head moderately to encourage the return flow of blood from the periphery and to give the brain first priority on any available oxygen circulating in the blood. (3) Support the circulation with intravenous fluids until blood or plasma is available. Occasionally vasoconstrictor drugs are of value in critical situations of this kind, but should not be used to the exclusion of more active supportive therapy. (4) Cardiac massage through the diaphragm should be instituted if the expulsive action of the heart has ceased.

#### A CASE REPORT

The following is a report of a case in which profound circulatory depression occurred during which effective expulsive cardiac action had apparently ceased for a short period:

White female, aged 49 years, weight 207 pounds, height five feet seven inches, with a history of hypertension, was scheduled for cholecystectomy. This patient was classified as a Class II anesthesia risk on the basis of her physical state. Premedication was one and a half grains of pentobarbital sodium, morphine grains 1/6 and atropine grains 1/150. Immediate preoperative blood pressure was 130/90. Seventy-five mgs. ephedrine were injected intramuscularly ten minutes before the administration of spinal anesthesia. Spinal anesthesia consisted of 10 mgs. nupercaine 1:1500 solution, administered in



the sitting position between the second and third lumbar interspace.

Patient was allowed to sit up for 90 seconds, during which there was no change in the character of the pulse, which remained at 88 beats per minute. As soon as the patient was placed level on the operating table an intravenous of 5 per cent dextrose was started. Oxygen was administered by face mask. Blood pressure leveled off at 110/85 and sensory anesthesia was complete to D 6. Supplementary anesthesia was started using cyclopropane to which a small amount of ether was subsequently added. Forty minutes after the spinal anesthesia had been injected and 30 minutes after the surgeon had started operating, massive hemorrhage occurred from the cystic artery. This hemorrhage was not immediately stopped but was brought under control shortly with several large packs. Blood pressure at this time was 120/90 and the pulse 80.

However, two minutes after the hemorrhage occurred the patient's pulse was imperceptible and the blood pressure was unobtainable. Respirations rapidly became depressed and ineffectual. An intravenous of 5 per cent dextrose was running at this time and the rate of flow increased; the carotid pulse likewise was not palpable. Mixture in the breathing bag was emptied, bag filled with oxygen and the patient was artificially respired by manual pressure on the breathing bag. The head of the table was lowered slightly. Since no peripheral circulation was apparently present the surgeon was requested to palpate the heart through the diaphragm and reported that no contractions of the heart could be felt. Surgeon was requested to massage the heart through the diaphragm while manual inflation of the lungs was being carried out. The mixture in the breathing bag was repeatedly emptied and filled with oxygen to wash out the cyclopropane-ether mixture.

Approximately 40 seconds after massage was instituted the surgeon reported that the heart had begun to beat feebly, very slowly at first and gradually increased in speed. Twenty-five mgs. of ephedrine were administered intravenously, the heart beat continued to improve in character, the pulse was shortly obtained at 80 beats per minute and blood pressure was recorded at 70/50. At this time the patient was practically awake. Circulation gradually improved and the blood pressure leveled off at 96/70. Blood plasma was connected on the intravenous set and the operation was completed without further incidence. Effective cardiac contraction had been absent for about 2½ to 3 minutes. After a rather stormy recovery the patient was discharged in good condition on the 15th postoperative day.

#### COMMENT

Poor risk patients do not stand even short bouts of anoxia well. Likewise patients in profound or deep surgical anesthesia withstand anoxia poorly. This patient suffered a severe bout of stagnant anoxia following severe hemorrhage, cessation of expulsive cardiac beats apparently resulted from cardiac anoxia in this patient who undoubtedly had an impaired circulatory system to begin with. Favorable outcome in this case was probably enhanced by: First, the short interval of profound depression that elapsed before the institution of resuscitative measures;

and, second, the fact that intravenous fluids were already running at the time the hemorrhage occurred. The prompt treatment that this patient received contributed, at least, in a measure to the favorable outcome.

#### SUMMARY

Factors that contribute to circulatory failure during anesthesia are discussed. A planned program for resuscitation in the operating room is recommended.

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### A Connecticut Plan For The Chronically Ill

In the field of health, as in other sciences, the solution of one problem gives rise to new problems. Medical science has succeeded in removing or, at least, controlling many diseases which shortened man's life span and annually ended the lives of a large percentage of the population. The layman is seldom aware of the social progress which has resulted from the successful solution of the problem of acute disease, even though this solution has been most remarkable and effective during the life span of the present older generation. What the layman sees, when he considers the health of his society, is a mountainous problem of long term physical impairment and disability; of disease which does not kill, but which prevents the efficient use of talents and skills and the enjoyment of a normal social life in the latter decades of life. These disorders are the new problems that have arisen with the increased life span. The layman sees not only that chronic illness may incapacitate him, but that all the savings from his life's work may be spent in the futile effort to recover normal health. Unaware that the "doctor" has not had a chance to draw his breath since his first assignment to save life, the layman is now asking, sometimes with impatience, why he hasn't done something about these chronic diseases. The doctor can only reply that he has just recently been able to start work on this problem but that he is confident of success if he is given time and cooperation, since controlling and preventing the chronic illnesses is more than a medical task; it is a problem for all of organized society.—Karl F. Heiser, Ph.D., Hartford; Conn. State Med. Jr., Vol. IX, No. 3, March, 1945.

# Still's Disease

S. H. ASHMUN, M.D.

**S**TILL'S Disease or Chauffard-Still's Disease, as it is sometimes known, is not a definite disease but is rather the name applied to a group of rather definite cases of polyarthritis that begin early in childhood often before the end of the first year. These cases present painful involvement of many joints often symmetrical, the enlargement of the spleen, though not always, and of the lymph glands as well. The blood picture varies from leucopenia to leucocytosis. The victims of this symptom complex are usually almost helpless and carry fever of varying degree, often making it difficult to rule out rheumatic heart disease and childhood tuberculosis.

Many authors have found the most frequent joints involved to be the fingers, the wrists, knees, cervical vertebrae, and sometimes the temporomandibular joints. The swellings are usually periarticular, on the fingers they assume the spindle or suppository shape, the amount of disuse sometimes results in osteoporosis. Amyloid degeneration of spleen, liver, and other organs has been found in cases that died after suffering several years.

A great many factors enter into the problem of childhood polyarthritis, such as congenital defects and anomalies, congenital dislocation, hemophilia, nutritional disturbances, growth processes, prevalence of acute infection and even the mode of life and standard of living of the parents. All these have their influence.

Most authors have found that girls, more often than boys, are victims of this disease. The British Isles have furnished a very large number of these cases. Heredity as in all forms of rheumatic disease is a prominent factor. Poverty, while a factor, is not as prominent as family tendency in this group of cases. The incidence of heart involvement is naturally not as large in any group of young children as it is in older groups, but many of these cases present cardiac involvement very early in the disease.

## TREATMENT

In any group of disease in which the recovery is so difficult and the course so long, it is natural that so very many varieties of treatment would have been tried and Still's Disease is no exception, but those measures that have proved of some value include the more or less forced nutri-

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tion with its very large doses of vitamins especially of vitamin D, which Strong et al., feel should be used to the limit (150,000 units daily).

I have never used doses of this size. Many value the use of the short wave diathermy, some "fever therapy", some the gold salts or "auric" treatment. The latter I have not used, because of warnings of undesirable symptoms that simulate the reactions obtained with nirvanol in chorea.

Probably because of finding the associated positive undulant fever tests in so many of my patients, I have come to follow a very definite but simple formula for study and management of these cases. I would recommend that if you have not tried such treatment you may do so with every prospect of the same encouraging results that I have had. I have stressed the dietary and anti-anemia treatment, using large doses of vitamins A, B, C, and D by mouth whenever possible so as to spare these patients the too often unnecessary hypo. I stress meat above all other foods, feeling that milk is of much less importance, and that patients will learn to eat vegetables if the excess of milk is withheld. I prefer to treat the child and not the joints alone. I believe most cases of Still's Disease to be caused by Streptococci and brucellosis or undulant fever.

## RECOMMENDED ROUTINE STUDY AND MANAGEMENT OF POLYARTHRITIS IN CHILDREN

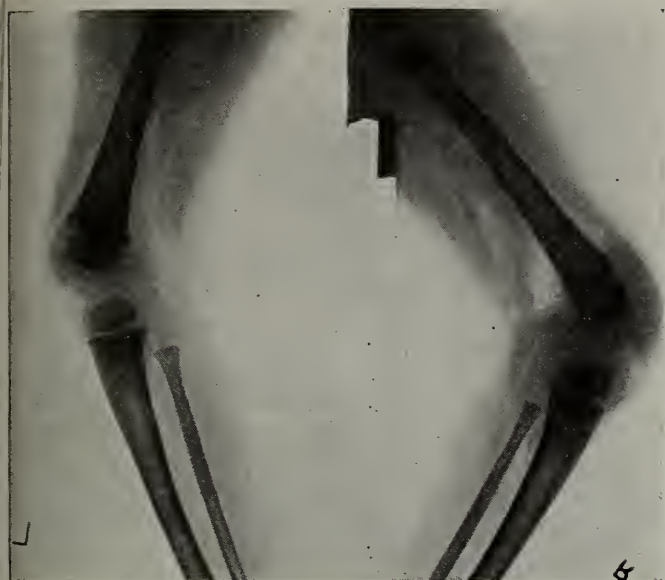
1. Routine physical and laboratory tests with special care to make blood sedimentation tests. Blood counts and patch tests for T. B. C., agglutination and skin tests for undulant fever as well as the Kahn test of syphilis, and X-ray studies.

2. Removal of foci of infection, usually in tonsils, nasal sinuses or dental abscesses, when the

Presented before the Section on Pediatrics, Ninety-Eighth Annual Meeting, Ohio State Medical Association, May 2-4, 1944.



## CASE IV



Case of J. R. Typical periartthritis of phalanges of knee. Patient also had cervical spine and temporo-mandibular involvement.



temperature, leucocyte count, sedimentation rate and season of the year permit.

3. Give each case a course of treatment with Streptococcus immunogen (combined) plus Streptococcus immunogen arthritis adding undulant fever vaccine to the treatment of those cases with positive skin or agglutination tests for undulant fever.

4. The weekly dose is 4 minims each of the Streptococcus immunogens, with the undulant vaccine added in the same syringe in amounts of 1 minim, 2 minims, 4 minims, and 8 minims. Continue every month with a maintenance dose of 4 minims of Streptococcus immunogen (combined), 4 minims of Streptococcus immunogen arthritis and 4 to 8 minims of the undulant vaccine according to reaction.

## CASE REPORTS

Case I. B.B. Four-year old girl seen May 27, 1937, having been treated several weeks for intermittent fever, painful joints with deformity, general glandular enlargement including large liver and spleen. Ht. 35 inches, Wt. 29½ pounds. There was rheumatic family history. She was a breech delivery; her T. B. test was negative; undulant skin test, positive; and Kahn was negative. T. & A. performed July 27, 1937. Response to sulfanilamide was very unsatisfactory, each attempt produced 105° temperature. She responded promptly to the combined streptococcus immunogens and undulant fever vaccine. July 15, 1940—she suffered a relapse but again responded promptly to repeated course of the Streptococcus immunogens and undulant vaccine. Child is now age 11—no relapse since 1940. Ht. 4 feet 7 inches, Wt. 78 pounds.



Case II. Seen April 14, 1938. Age 10 months. Girl, Wt. 20 pounds. Had rapidly lost 6 pounds. Acute Streptococcic tonsillitis, broncho-pneumonia, cardiac enlargement 4 plus. Nodes on spine, arms and scalp. These were tender to touch (usually said to be non-tender). X-ray showed negative spine—pericardial effusion. Sedimentation rate 18 mm. in 30 minutes. She was treated with multiple small transfusions and Streptococcus immunogen. T. & A. August 18, 1943, after severe relapse. Had severe pertussis and was treated by pertussis antigen followed by course of Streptococcus immunogen and undulant vaccine. April 2, 1943—Wt. 40 pounds; had chorea but responded to mapharsen. November 5, 1943—Wt. 43 pounds, Ht. 45½ inches.

Laboratory Test: Blood culture, negative; spinal fluid culture, negative; spinal fluid sugar, 12.6 mg.; R. B. C. 4,400,000; W. B. C. 18,000. Rx Transfusions, diathermy treatments, vitamins

and minerals, *Streptococcus immunogens* and undulant vaccine.

Case III. B.T. Onset August, 1942. Age six. Wt. 44, Ht. 34 inches. White boy of English and Spanish parentage with rheumatic family history. Chief complaint—loss of weight, polyuria, polydipsia, profuse perspiration, vomiting, and epistaxis, irregular fever, pain in legs and hands. Physical revealed a thin boy with general adenitis, heart enlarged slightly with soft systolic murmur heard only in prone position. His small joints were enlarged spindle shaped. He had the customary unhappy look.

Laboratory Test: Kahn, negative; P. P. D. No. 1, negative; urine negative; specific gravity 1006-1030; hemoglobin 10.7 gms; R. B. C. 4,040,000; W. B. C. 7,800; polys 65 per cent; eos. 2 per cent; lymphs 28 per cent; monos. 5 per cent; stools negative; ova. Negative for pathogens; typhoid and paratyphoid agglutinations were negative; abortus and para-dysentery negative; throat cultures—hemolytic streptococci predominated. Fasting Blood Sugar: 82 mgs. per cent;  $\frac{1}{2}$  hr. 155 per cent; 1 hr. 140 per cent; 2 hr. 91 per cent; 3 hr. 75 per cent. All urine specimens negative. Sedimentation O. S. R. 1.63 mm. per minute C. V. 34 C. S. R. 91. Upper limit of normal about .35; R. B. C. 3,966; Vol. R. B. C. 32.1; Hb. 10.9 Gm; size 81.0 cu. microm; Hb. content 33.8; corrected sedimentation rate .70 mm. per min.

X-ray of skull showed moderate convolutional atrophy and cranial bones negative. X-ray of chest showed hilar and bronchial markings increased. X-ray of long bones—negative. X-ray of fingers and toes showed spindle shaped enlargements; cyst like area last phalynx of left index; epiphyseal development on schedule and normal.

Diagnosis: Chronic infectious arthritis (Still's Type).

Case IV. Julia R. Eighteen-month old girl with extremely painful wrist, fingers, knees and cervical spine. Glandular enlargements and temperature 99<sup>+</sup> to 103<sup>+</sup>. June 15, 1943—T. B. Patch, negative; Wt. 20½ pounds, Ht. 30½ inches, brucellosis agglutination—Positive—Dilution 1:200; Kahn, negative; hemoglobin 13 gms.; W. B. C. 12,550; sedimentation 15 mm.-15 min., 28 mm. - 30 min. Later test on sedimentation rate 20 mm. in 1 hr. January 3, 1944—The child had temporo mandibular joint involvement with marked parotid swelling resembling mumps. She has not had a T. & A. although her tonsils are always 4 plus. She has had a course of *Streptococcus immunogens* and undulant vaccine but she will not be permanently relieved till the tonsil focus is removed. It is hoped that her sedimentation rate will be reduced enough with continued salicylate treatment, according to Coburn, to en-

able us (if permitted) to have her tonsils removed. She exemplifies the need of the combined treatment, viz., removal of foci of infection, high vitamin and mineral intake together with the *Streptococcus immunogen* arthritis and undulant vaccine.

#### SUMMARY

1. Brief review of Still's Disease, its characteristics, incidence, etc.
2. Case reports.
3. Formula for study and management of cases.
4. Conclusions expressed that much oftener than now recognized. Brucellosis, as shown by skin test, may be an important factor in Still's Disease.

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#### Virus and Cancer

The most striking development in the virus field has been in the transformation of the Rous sarcoma virus by passage through new born and adult avians of the same or of different species. In new born ducks following intravenous injection with the virus two types of tumors developed. One type came early within thirty days. It showed characteristics of sarcoma growing in chickens and was transmissible to chickens but not to ducks. The tumors which were delayed in appearance for several months after injection were different in type from the chicken sarcomas. These tumors were transmissible to ducks but not to chickens. The virus had undergone variation in this passage. Many other variations in the passage were worked out. Several duck variants of the Rous virus were thus originated. Similar experiments were successful in turkeys and guinea fowls.

Taylor implanted the yolk sacs of five day chick embryos with saline suspensions of fresh tissue from a spontaneous mammary carcinoma of a dba mouse. After 12 days of incubation the yolks of these eggs (which had relatively large growing tumors) was diluted and passed through an N sized Berkefeld filter. Dbm mice injected with this filtrate grew tumors which were transplantable, rapidly growing, histologically malignant and which metastasized to the liver and peritoneum. The evidence favored a virus substance, which was caught and preserved by the surrounding yolk. This work should be confirmed.—John J. Morton, M.D., Rochester, N.Y.; Conn. State Med. Jr., Vol. IX, No. 3, March, 1945.



# Medical Service, the First Step to Rehabilitation

WALTER J. ZEITER, M.D.

REHABILITATION of the disabled is one of the foremost problems of the day. The disabled person is being given increased attention because every resource of manpower must be utilized to meet pressing needs. The new law (Public Law 113, 78th Congress), known as the Vocational Rehabilitation Act Amendment of 1943, greatly broadens and strengthens the rehabilitation program.

## THE LAW

This law will affect medicine in all its branches. The original Act, passed in 1920, provided for the "promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment". As amended it provides, in addition to vocational training and placement in jobs, "corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical condition which, if 'static', constitutes a substantial handicap to employment, but is of such a nature that such correction or modification should eliminate or substantially reduce such handicap within a reasonable length of time".

In general, according to Michael J. Shortly,<sup>1</sup> director, Office of Vocational Rehabilitation, Federal Security Agency, Washington, D.C., "The rehabilitation services available under this program will include medical and vocational diagnoses, vocational guidance, physical restoration, vocational training, funds for maintenance during training, and placement in remunerative employment. All handicapped persons eligible for service may receive medical and vocational diagnosis, guidance, training, and placement services irrespective of their financial status." However, eligibility for Federal aid in physical restoration services is based upon proof that the applicant is unable to pay from his own resources for such services as prosthetic appliances, for maintenance during training, and for instructional supplies such as books and tools.

There are certain other limitations in the administration of restoration services. In the first place, the services to be rendered must be expected to reduce substantially or eliminate the employment handicap. Also, the treatment may be given only for conditions which are "static". This term was intended by Congress to differentiate ordinary acute illness or injury from conditions to be treated under this program. The bill limits hospitalization to ninety days for any one disability.

<sup>1</sup>Read at Cleveland Health Council's Institute on Vocational Rehabilitation, Cleveland, Ohio, Fenn College, November 17, 1944.

## The Author

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Extensive clinical service will be required for the effective administration of a law primarily designed to accomplish the physical restoration of handicapped persons and to assist them to obtain suitable employment. In many instances in addition to rehabilitation centers use must be made of the best qualified specialists, superior facilities, and the most modern hospitals.

## STATE PROGRAM

Mr. Marlow B. Perrin, director, Bureau of Vocational Rehabilitation of Ohio, has explained to you the present State program. The Advisory Council of the Bureau of Vocational Rehabilitation has appointed a Medical Advisory Committee of which Dr. Edward Harlan Wilson, of Columbus, is chairman. This committee has been asked to consider the following problems:

1. Method of supervision of medical care.
2. Qualifications for treatment of disabled persons.
3. Determination of qualifications for treatment in the various branches of medicine and surgery.
4. Medical fee schedule.
5. Standards of hospitalization.
6. Basis for determination of hospital charges.

In most instances medical consultation will be necessary to evaluate the problem of the disabled, to determine the patient's condition, and also to evaluate whether or not the person can be benefited or his condition so improved that he may earn a partial or total livelihood.

Many conditions are disabling, and it would be impossible to enumerate them fully. In the Appendix to the Tomlinson Report on Rehabilitation<sup>2</sup> published in Great Britain the disablements are classified as follows:

1. Fractures or other physical injuries.
2. Other surgical conditions and the general medical cases.
3. Cardiac cases.
4. Pulmonary tuberculosis.
5. Blindness.

6. Deafness.
7. Neuroses.
8. Psychoses.

From this list of disabilities it is at once clear that a medical examination is the first step in determining the possibility of rehabilitation.

#### THE AMENDMENT

The amendment to the Vocational Rehabilitation Act specifies that each disabled person is to obtain a physical examination and to have such laboratory studies, i.e., X-ray, blood chemistry, and others, as are necessary to determine his physical condition. Because of the great variety of disabilities it is obvious that in a program as broad as this frequent consultation with specialists, such as orthopedists, industrial surgeons, cardiologists, phthisiologists, psychiatrists, physical therapy physicians, and internists will be required. Some instances will involve the use of special institutions for the study of the patient, such as a general hospital, orthopedic center, tuberculosis hospital or sanatorium, special centers for the study of neuroses, and mental hospitals.

After the medical study of the patient is completed and the diagnosis made, a final evaluation can be made by the physician as to whether or not the patient can be benefited by operation, medical care, physical medicine, prosthetic appliances, or braces. After it has been decided to proceed with treatment, a program should be laid out for the patient, making full use of all special services.<sup>3</sup> In many instances phases of this program will have to be coordinated, and the whole should be carried out under medical supervision so that the progress of the patient may be observed from time to time and indicated changes in the form of therapy made to aid the patient in making the most rapid improvement and progress possible.

#### PHYSICAL AND OCCUPATIONAL THERAPY

The law provides for the use of physical therapy, occupational therapy, and speech therapy. During and after World War I physical and occupational therapy became well established. In the present conflict, because of the tremendous number of disabled men, physical therapy and occupational therapy have expanded tremendously, and their value has become more firmly established. A brief discussion of physical therapy, occupational therapy, and speech therapy may clarify the methods of treatment used and the part which each plays in the rehabilitation of the disabled.

#### PHYSICAL THERAPY

Physical therapy may be defined as that science which deals with the management of diseases by means of physical agents, such as

light, heat, cold, water, electricity, and mechanical agents. The fundamental principle involved in the use of physical agents is the production of hyperemia and relaxation of the affected part. Massage may also be used to produce relaxation and to improve circulation. Therapeutic exercises may be active or passive, with or without apparatus, and have a definite value in restoring diseased or injured tissue to as nearly normal function as possible. Hydrotherapy, particularly whirlpool baths, Hubbard tanks, pools, and packs may be used extensively to serve any of the aforementioned basic principles.

Electricity in the form of low-voltage current is of particular value in the diagnosis and treatment of certain nerve lesions and also is a means of stimulating weakened or paralyzed muscles. Various forms of heat such as infra-red or short wave diathermy have definite applications. Apparatus, such as stall bars, graduated stairs, rings and pulleys, or the shoulder wheel, may be used in a well rounded program of therapy.

The physician should compare the actual progress with the expected improvement and adjust the program when necessary. When a long-range program is outlined, the patient should be returned to the referring doctor from time to time so that he may also observe the progress. Physical therapy treatments are given by a trained technician under the direction of a physician, in many instances a physician trained in physical medicine.

Frequently a combination of physical and occupational therapy is more effective than the use of physical measures alone. When indicated, occupational therapy should be started early.

#### OCCUPATIONAL THERAPY

Occupational therapy is treatment based on activities and is an essential part of any rehabilitation program. It may be defined as an activity, mental or physical, used to hasten recovery from disease or injury. It is provided by a definite program scientifically supervised by trained technicians in which some mental or physical activity is designed to overcome functional disability, improve morale, and reestablish the patient's usefulness.

Occupational therapy may be divided into avocational and vocational programs, which may be further subdivided as follows:

1. Functional occupational therapy is a program of graded activity employed to restore articular and muscular function, to improve the general condition, to build up strength and physical endurance, and to aid in mental rehabilitation. It is based on the theory that actual effort by the patient to use the disabled part is necessary for the return of function.

2. Diversional occupational therapy comprises



simple recreational activities designed to divert the patient's thoughts from himself and his disability and to arouse his interest, courage, and confidence as well as to improve his morale and general physical well being through active participation in an activity.

3. **Prevocational occupational therapy** is work planned to prepare the patient either to return to his former job or to undertake vocational training.

As physical therapy and occupational therapy supplement each other, it is very important that they be coordinated in the rehabilitation program. Heat and massage prepare the part for active exercise. Preparatory physical therapy should be followed immediately by active exercise in occupational therapy, and the two departments should, therefore, be located close together, and the schedules dovetailed. Both departments should be under medical supervision.

#### THE METHODS

All tasks in occupational therapy should be simple so that the patient does not spend too much time in learning them, and so that the task may be easily analyzed by both the patient and the occupational therapist to determine whether the desired motion is being made. There should always be a specific goal to the task being performed, and it should not be justified on the grounds of making the patient happy or keeping him amused.

To accomplish the desired results treatments should be given often; three times a week is the minimum, and five or six times a week is preferred if the patient is to get the maximum benefit. The tasks must be carefully graded as to physical activity and should gradually be made more difficult, the aim being to keep the task just one step ahead of the patient in his progress. Monotony must be avoided at all times. The psychological stimulation to a patient engaged in occupational therapy of talking with other handicapped persons and of seeing what others accomplish and how he may improve is a big boost to morale which can not be achieved in any other way.

#### THE EQUIPMENT

The equipment need not be elaborate. The essentials are a bicycle saw and lathe, floor looms, woodworking tools, and games, such as shuffle board, floor dominoes, and checkers. Wall painting and wall washing can be advantageously used with very little cost. If the type of motion desired is explained, many patients intelligent enough to grasp the purpose of the task may engage in occupational therapy at home with periodic medical supervision.

Speech difficulties or defects are not infre-

quently part of the disabled patient's problem and may interfere with gainful employment. Speech therapy centers are usually associated with universities and are equipped to handle simple as well as very difficult speech problems which may involve the use of complicated and extensive mechanical equipment.

In addition to frequent medical and social consultation the plan of treatment for a patient with a speech defect should include the service of a person trained to undertake work in speech correction and in the treatment of long-term cases requiring many types of therapy. Speech therapy procedures differ greatly with the various problems to be treated. They may be primarily auditory, visual, or kinesthetic in approach, and they may involve phonetic principles, application of the physics of sound, or exercises to improve muscular coordination or relaxation.

#### SUMMARY

I believe that the part that medical care will play in the rehabilitation of the disabled has been well stated by Captain Charles F. Behrens (MC) U.S. Navy, in his report of the Subcommittee on Rehabilitation of the Baruch Committee on Physical Medicine:<sup>4</sup>

"Rehabilitation could be considered as embracing nearly all of medicine and surgery. Certainly it goes beyond mere rebuilding or repair. It involves what could well be called 'reconstructive medicine' since it means the restoration of people handicapped by disease, injury or malformations as nearly as possible to a normal physical and mental state and in the case of those permanently handicapped, to develop in them compensatory skills and adjustments both physical and mental."

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For many years childhood tuberculosis has been confused with first infection type of tuberculosis. While it is true that the course of tuberculosis is strongly modified by the age of first infection, the first attack is generally similar at any age, making due allowance for the type of tissue in which the lesion occurs. The relationship of this and other diseases such as rheumatic fever and infantile paralysis to the growth process is therefore of great pediatric importance and the subject is one for research examination.—Hugh McCulloch, M.D.—Minn. Med., December, 1944.

# Venography of the Lower Extremities

E. C. BAKER, M.D.

WE have had three reasons for doing this work. When we started there was no background of literature or other experience to give us adequate information about physiology and anatomy of the venous structures of the leg and arm. It was necessary to establish, first of all, some normal or base line. This was done by investigating patients with no history of previous trouble and no obvious clinical evidence of trouble. Following this, we soon found that in pathological cases we were able to offer very exact and highly diagnostic information about the status of the venous system in the lower extremities.

The last reason involves the highly dramatic question of emboli. In recent years there has been increasing evidence that most emboli come from the lower extremities. In such cases, venography can, and does, show the start and position of these processes in the lower leg. The surgeon with such information at his command is enabled to perform operations which reduce the morbidity and at times becomes a life-saving measure.

## TECHNIQUE

The technical factors utilized in this procedure will be briefly mentioned. The dye, diodrast, is injected through a 25 or 27 caliber needle into any accessible vein below the ankle over a period of two to three minutes. During this time multiple exposures are taken of the leg, knee, thigh, and lower abdomen. The films are made from stereo positions to better localize the structures of the venous system. We then have a serial film study, extending over a period of several minutes, covering the entire lower extremity and pelvic region. Such a serial study in most cases gives us adequate visualization of the functional part of the venous system at the time the study was made.

Automatically, the venous system of the lower extremities is best described in two parts, the superficial circulation and the deep circulation.

The superficial circulation is composed of a venous plexus of varying appearance which extends from the foot to the region of the upper thigh. The main collecting vein from the superficial system is the internal saphenous. The internal saphenous vein starts in the region of the fossa ovalis and runs downward on the inner

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portion of the thigh, knee, and leg. It can usually be traced as a single trunk almost to the ankle.

The deep circulation starts in the region of the fossa ovalis as the femoral vein and extends downward through the thigh following the course of the femoral artery to the popliteal space. It here becomes the popliteal vein. The popliteal vein varies in length and breaks up either above, behind, or below the knee into two or three main veins which follow the main arteries of the leg. These veins proceed downward through the leg close to the interosseous space and can usually be traced as trunk veins to the region of the ankle. The junction of the femoral vein and of the internal saphenous vein in the region of the fossa ovalis forms the external iliac vein which carries the blood supply upward into the body. It is not infrequent to find the femoral vein divided into two, three, or four parts.

Connecting these two main systems of veins we find numerous anastomoses between the superficial and the deep circulation in both leg, knee, and thigh areas. The external saphenous vein, frequently mentioned in the text books, has been a very inconstant vein in our experience. It is usually part of a superficial plexus of veins rather than a single well-defined trunk.

Knowledge of anatomy is not sufficient to produce technical results which can be adequately interpreted. The rate of upward flow of the blood stream in the lower extremity is an important part of the problem both from the technical standpoint of when to take the films and from the standpoint of the interpretation of the films obtained.

## THE UPWARD FLOW

A very simple procedure has been followed which has given us adequate information about the necessary timing of the films. At the time each separate exposure is made, the number

Presented at Annual Meeting of Ohio State Radiological Society held in conjunction with Ninety-Eighth Annual Meeting of the Ohio State Medical Association at Columbus, May 2-4, 1944.



of cc. of dye injected, and the time elapsed from the start of the injection, is recorded. Such notes quickly give a quantity of data from which average conclusions may be drawn. Such data will also explain many times non-visualization of parts of the venous tree where upward passage of the blood is extremely slow. Normally, during the time of the injection, the venous tree of the lower leg, up to, and including the knee, can be visualized well from the end of the first minute, after the start of the injection, to the end of the time that the injection is made. The veins of the thigh are visualized best in the following one to two minutes.

Occasionally, a case is found in which the upward passage of the dye is extremely slow, and the dye may not reach the mid-thigh for a period of three to four minutes. Our experience has been that the upward passage of the dye and the blood stream in the lower extremity from the region of the foot, upward to slightly above the knee, is very much slower than comparable passage of the dye in the upper extremity. Above the knee, the dye usually passes more rapidly and the rate of flow approximates the rate of flow seen in the upper extremity. It must always be remembered in interpretation of the films obtained, that the procedure is a demonstration of physiological processes as well as a demonstration of anatomy.

The usual question asked about this type of work, and the question that was paramount in importance in our own minds when the work was started, relates to the above-mentioned factors of physiology and anatomy. How can it be expected that dye injected into a very tiny vein of the foot can visualize the main venous channels of the leg and thigh? We know that in the normal case we have been able to do this.

#### THE VISUALIZATION

I believe the reason that such visualization occurs is a physiological one. The venous system is essentially a tremendous plexus of veins which communicate very freely. Blood spreads from one particular point through this plexus of veins rapidly and easily. Physiologically, certain of these veins in the plexus gradually become main physiological channels. These main physiological channels take up more and more of the load as the venous system approaches the heart. As dye is injected into the venous system it will spread first of all into the venous plexus and gradually as it returns closer to the heart will be found in increasing amount in the main physiological channels.

Actually, experience shows that in the normal case the superficial plexus will be visualized and the deep veins which are functioning will be visualized. In the pathological case, repeated evidence tends to prove that proper visualization

of the functioning venous channels will be obtained with the routine described above.

Venograms yield highly diagnostic information. Most of the pathology in the veins causes a block in the passage of the blood through a portion of the superficial or deep circulation. The extent and position of this block can be demonstrated by venography. In a small percentage of cases the cause of the block will be shown.

For example, the thrombus within a vein may be demonstrated in several ways. If the thrombus blocks the vein completely, the lower end of the thrombus may be shown by the abrupt stopping of the upper end of the column of dye. If a small amount of blood is proceeding past the thrombus the thrombus may be visualized as a filling defect in the central portion of the vein. If the thrombus is a mural thrombus and is attached to the wall of the vein, the ragged constant appearance of the vein wall in a particular section will demonstrate such pathology. Where thrombosis has occurred a long time previously and recanalization of the vein is seen, the constant, ragged appearance with multiple filling defects within the vein is recognizable.

#### TYPES OF THROMBOSIS

It is not usually possible to differentiate between so-called bland thrombosis or phlebothrombosis or traumatic thrombosis and infectious thrombophlebitis. At times, however, certain findings may point toward the differentiation between these two types and pathology. From the standpoint of surgical procedure, however, a demonstration of position and extent of the block is most important to the surgeon.

A rough classification of the blocks demonstrated would consist of dividing the area of block into superficial or deep positions. Again, both of these blocks can be divided into acute or chronic processes. In normal veins and in acute pathology of the veins, the veins demonstrated will be fairly straight, not tortuous, and of very even and rather fine caliber. In the case of chronic pathology where the block has been of long-standing, the veins demonstrated will be tortuous, dilated, and of considerably greater diameter than usually seen in the normal. In some cases, both the deep and superficial circulation is involved. In all cases, with acute block of the deep circulation evidence can be demonstrated of block of a portion of the superficial circulation also.

Where chronic pathology and acute pathology exist together it is not always possible to determine by venogram the area of acute pathology. However, the area of block is demonstrated and this is the important information for the surgeon. Where areas of block are demonstrated in deep or superficial circulation, it has been seen repeatedly that the dye moves with surprising ease

around such areas by means of communicating veins and other veins in the plexus. A number of observations have been made that as soon as possible the dye will return to the main physiological channels above the block. Valves, in our experience have been quite variable in number and in normal and in abnormal cases, have been shown to be completely incompetent.

From the clinical side, this procedure has on a number of occasions proved to be more exact than clinical tests. A small number of cases will, from the clinical examination available, give results that tend to show that the deep circulation is patent. Venography, however, will demonstrate in these cases that the deep veins are not carrying any blood supply. If these particular cases have the internal saphenous vein, which is usually the most important physiological channel remaining, tied off, then the patient is worse off than before the operation. A number of such cases have been saved operation and the resulting increased morbidity.

The most dramatic part of the procedure is in those cases where post-operatively emboli have been demonstrated in the lung field. Venography, in these cases, will show the extent of the acute block and in a number of instances, in our hands and elsewhere, proved to be of life-saving value. We feel that if more careful attention were paid post-operatively to the diameter of the legs, especially the region of the calf, and to any possible pain in this area, and a constant effort made each day to determine whether Homan's sign exists or does not, many of these embolic cases would be picked up before the emboli had a chance to reach the lung, and with proper surgical procedure, both morbidity and mortality could be lowered.

#### SUMMARY

In summary then, venography has demonstrated with a high degree of accuracy, normal anatomical and physiological venous return from the lower extremity and has given highly diagnostic information in pathological cases. Such information has enabled the surgeon to proceed accurately both in the chronic and acute case. It has also saved the surgeon from making mistakes which were unavoidable in the past. The usefulness of the procedure is only beginning to be appreciated.

Hippocrates was of the opinion that the umbilical cord should not be severed till the child had urinated, sneezed or cried vigorously. His favorite theme was the viability of the newborn. There are at least twenty references in the Hippocratic literature on this subject.—Isaac A. Abt, M.D., Chicago, Ill. Med. Jr., Vol. 87, No. 1, Jan., 1945.

## KEEPING UP WITH MEDICINE

**I**N rupture of the lumbar intervertebral disks, the onset of symptoms in most cases is related to an injury such as lifting, a wrench, or a fall on the buttocks. Repeated attacks are the rule. In the earlier attacks the pain is limited to the lower back. Eventually, however, sciatica develops and is the outstanding symptom in practically all cases that come to operation.

\* \* \*

**O**UR only hope of solving pound problems, with which the great increase of persons over 65 years of age living in our midst has confronted us, is in further developments in the science of nutrition. Not only must it give us more information about the specialized needs of old people, but, which is more important, what are the optimal needs of persons in the middle age groups in order to retard the process of aging. We must divorce aging and diseases, not only in our social concepts but in fact, if society is not to be overwhelmed.

\* \* \*

**I**N general, patients with cirrhosis have relatively little hair. It is unusual to observe it in a hairy patient.

\* \* \*

**B**Y no stretch of the imagination can vitamins be expected to relieve fatigue, restore "pep", or prevent infections when these conditions come about from causes other than vitamin deficiencies.

\* \* \*

**O**CUPATIONAL dermatitis may be developed because of an allergy to chemicals used to bleach flour. We have seen several cases due to allergy to wheat itself. Flavoring agents, chiefly cinnamon and vanilla, used in cakes have also been responsible for a good many cases of dermatitis among bakers.

\* \* \*

**I**T is interesting to note recently the successful use of sulfadiazine in reducing the incidence of colds in hundreds of thousands of service men to whom this drug was given in small prophylactic doses daily. Since virus vaccines do not so protect and since sulpha drugs are known to be valueless in virus diseases, it would seem probable that the common cold is not a virus disease after all.

\* \* \*

**M**ENOPAUSE can be considered primarily as a withdrawal of estrogen from the system.—J. F.



# Foreign Bodies in the Gall Bladder: Case Report

THOMAS F. HEATLEY, M.D., and GEORGE W. BASCOM, M.D.

Mrs. M. B., age 61, a white female, presented her chief complaints as pain in the left hypochondrium, a loss of appetite and an approximate loss of 25 to 30 pounds of weight in the past year. One year ago she had an acute severe episode of pain in the right subcostal area, which apparently was cholecystitis in nature and severe enough so that she called a physician to treat her. The physician told her that she probably suffered from a chronic gall bladder disease, and probably gall stones. She apparently made an uneventful recovery from this acute episode of illness.

However, she states that since that time there has been some varying degree of tenderness and soreness in the right upper quadrant of the abdomen. She has been intolerant to fatty foods and has had increasing episodes of epigastric distress and pain. These episodes have been such that she has limited her diet to the extent where she has little appetite and takes warm tea and toast and cooked cereals and very little meat. The remaining part of her history is not contributory to her present illness.

Physical examination reveals: white female lying quietly and comfortably in bed, who is not apparently acutely ill. She shows obvious evidence of weight loss. The skin is dry and has a loss of elasticity but is not jaundiced. She is intelligent and cooperative. The blood pressure is 160 systolic and 90 diastolic expressed in millimeters of mercury.

**Head:** Scalp, ears, nose and mouth are normal.

**Eyes:** The sclera is clear, pupils are negative and round and react to light and accommodation. Examination of the ocular fundi shows arteriolar changes comparable to a Grade II change.

**Neck:** Thyroid gland is not palpable. No palpable glands or pulsating vessels or other tumor masses.

**Chest:** The chest is symmetrical and both breasts are atrophic and there are no palpable tumor masses in either breast. The respiratory excursions are free and equal. The percussion note is normal in both lungs. The tactile fremitus is normal and the breath sounds are normal throughout both lungs.

**Heart:** The heart is not apparently enlarged. There are no palpable thrills on auscultation, the rate and rhythm are normal. There are no murmurs over the valvular areas.

**Abdomen:** There are no scars or apparent tumor masses. There is definite tenderness on deep palpation over the gall bladder area. The liver, spleen and kidneys are not palpable.

**Pelvic Examination:** On bimanual examination of the pelvis, the cervix is found to be small and firm. Uterus is small and of senile type. There are no palpable masses in either adnexa and the cervix is freely movable without pain.

**Rectal Examination:** Reveals normal sphincter tone and a normal rectal cavity.

## The Authors

• Dr. Heatley, Toledo, Ohio, is a graduate of the University of Michigan Medical School, 1911; fellow, American College of Surgeons; chief of Surgical Division, Mercy Hospital.

• Dr. Bascom, Toledo, Ohio, is a graduate of Marquette University School of Medicine, 1937; member, Department of Medicine, Mercy Hospital.

**Extremities:** Both upper and lower extremities show no evidence of bony deficiency and the musculature of the extremities is normal. Reflexes are physiological and the sensory motor response of the skeletal muscles is normal.

**Laboratory Findings:** Urinalysis: Reaction was alkaline 7.5, Specific Gravity 1.009, albumin negative, sugar negative, microscopic examination shows nothing contributory. Blood Work: W.B.C. 7,050; R.B.C. 4,350,000; HBG. 84 per cent. Differential Count: Eosinophile 2 per cent; segments 69 per cent; lymphocytes 27 per cent; monocytes 27 per cent. The sedimentation rate was found to be 10 millimeters in 60 minutes (which is normal according to our method). The blood Wasserman is negative. N. P. N. 43 milligram; Sugar 81 milligram.

**Plasma Protein:** Total protein 6.9 per cent; Albumin 4.5 per cent; Globulin 2.4 per cent.

**X-Ray Examinations:** First the Barium Enema: The opaque enema filled the colon without difficulty showing numerous diverticula in the sigmoid portion and a few diverticula scattered along the remainder of the colon. There was no obstruction or filling defect. Terminal ileum appears normal. A film after evacuation shows good emptying.

**Impression:** Diverticulosis.

**Cholecystograms:** Show a gall bladder shadow of fair density. There are two metallic foreign bodies in the gall bladder. These are apparently needles and each of them is 3.5 cm. in length. In addition there is at least one oval calculus in the gall bladder.

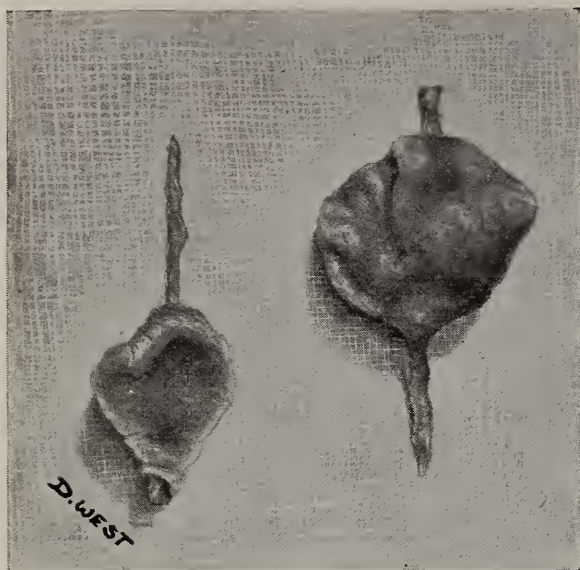
**Impression:** Metallic foreign bodies in the gall bladder and cholelithiasis.

**G. I. Series:** Plain film of the abdomen shows the two metallic foreign bodies in the right upper quadrant. Otherwise no definite abnormality.

Barium meal showed a normal esophagus. The stomach was smooth in outline with normal rugae, normal peristalsis and no residue at six hours. The duodenal cap lies immediately below the metallic foreign bodies, and the upper portion of the cap showed a smooth pressure defect which suggests that the gall bladder and the duodenum are adherent. There is a small diverticulum projecting downward from the second portion of the duodenum. At six hours the stomach is empty. Barium has reached the splenic flexure. The appendix and right half of

Submitted July 17, 1944.

X-ray studies by Drs. Deming and Donovan, Toledo, Ohio.



Calculi adhering to the pins.

the colon are well visualized. A film at twenty-four hours shows normal progress. There are scattered diverticula along the colon.

Impression: Diverticula of duodenum and colon. No evidence of intrinsic lesion of the stomach.

#### DIAGNOSIS

It is our opinion that the patient's discomfort and pain in the left upper quadrant of the abdomen is due to her chronic cholecystic disease associated with the foreign bodies in the gall bladder, rather than due to the diverticula which we feel were coincidentally demonstrated in the routine examination of the colon. Because the patient did not have any particular tenderness over the area of the splenic flexure of the colon or the sigmoid portion of the colon, it is our interpretation that the current complaint of pain in the left upper quadrant of the abdomen is apparently a reflex spasm of the colon caused by the continued irritation of the foreign bodies in the gall bladder and the chronic cholecystic disease. In view of these facts, it was decided to treat this patient surgically and remove the gall bladder.

A high right rectus incision was made and as the gall bladder was approached, the duodenum was found to be densely adherent to the gall bladder so that blunt and sharp dissection had to be employed to free the duodenum from the gall bladder. The liver was found to be normal except there were dense fibroid adhesions anchoring the gall bladder firmly in its bed, apparently where the metal pins had perforated the gall bladder into the liver bed in an effort to migrate into the liver tissue.

The post operative course of the patient was somewhat complicated by her intolerance to sedative medication and pneumonitis which developed on the sixth post operative day. Patient re-



Pins removed from the gall bladder showing the pins with attached calculi.

sponded well to treatment and the remaining part of her convalescence was uneventful.

#### DISCUSSION

It is so uncommon that one finds peculiar foreign bodies in the gall bladder, that we feel this case is of interest and worthwhile reporting.

In this particular case, we were able to make a pre-operative diagnosis, on the basis of X-ray examination, of foreign bodies in the gall bladder, which apparently were metallic in nature and simulated metal pins, and one oval calculus was demonstrated, roentenographically.

In reviewing the literature, we find other such cases reported by C. G. Toland, who reports, in his review of the literature, having found steel needles in the gall bladder. However, I believe this is the first occasion that such a case has been reported in our particular community, and as far as our hospital records are concerned, it is the first case of having found foreign bodies of this particular nature in the gall bladder.

One of the interesting aspects of this particular case is the problem of how these metallic pins entered the gall bladder. In the patient's history, she states that approximately 20 years ago she swallowed a safety pin which was closed. Also, for the past 30 years she has been a dress-maker and very commonly held many pins in her mouth while fitting clothes. She is able to recall frequent occasions when she thought she may or may not have swallowed a pin.

Whether or not these metallic pins, which were found to be in the gall bladder, was the safety pin which had been swallowed some 20 years ago and the spring and clasp ends of the pin having been gradually oxidized and the two shafts of the pin left relatively free and the two pins





Calculi and pins.

penetrating the duodenum into the gall bladder, or possibly the patient may have swallowed so-called "common pins" (straight pins) during the course of her dressmaking work, on two different occasions and both pins eventually perforating the duodenum and into the gall bladder, is a question which will have to remain unsolved. At any rate, it is very interesting to speculate on the possibility of each pin having been swallowed at different times and the very unusual possibility of both pins eventually being lodged in the gall bladder because of the many different routes which such a foreign body could have traversed, the rare possibility of a second pin following the course of the first pin is certainly a most unusual situation.

In reviewing the literature on the type of foreign bodies found in the gall bladder, some of the particular objects have been gauze sponges,



Gall bladder with the dye in the gall bladder.

parts of surgical instruments, rubber tube drains, pieces of fine wire, watermelon seeds and rifle bullets. In our particular case, these pins had been lodged in the gall bladder sufficiently long enough so that definite soft calculi had formed on each pin, simulating a nail with a large head, and we feel that is perhaps the reason that these pins did not penetrate the gall bladder and eventually find their way into the parenchyma of the liver.

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#### Asphyxia Neonatorum

In America Dewees (1833) thought that the infant might be feeble at birth due either to delay in its delivery or compression of the cord. John Eberle, another American pediatric writer, stated in 1834 that asphyxia might be caused by "the unceasing and vehement uterine contractions frequently excited by the use of ergot." He said it was difficult to conceive how a long-continued powerful action of the uterus could fail to produce dangerous and fatal sanguineous congestion in the brain. P. Cazeaux made the important contribution opposed to previous views that the livid and the pallid or the so-called apoplectic and anemic asphyxias were only different stages of the same process.—Isaac A. Abt., M.D., Chicago; Ill. Med. Jr., Vol. 87, No. 1, Jan., 1945.

#### Diagnosis of Tinea Capitis

For the diagnosis of tinea capitis, Wood's light is the first essential article of special equipment which is needed. This light consists of ultraviolet rays which are filtered through a special type of Corning glass. The complete equipment for producing these rays is an expensive apparatus which is not generally available and hence is not practical for general office use. We have been using an inexpensive substitute, the Westinghouse Purplex lamp which is an efficient diagnostic light that will fit into any standard light socket. It must be flashed intermittently, because its construction will not permit it to burn steadily for more than a few seconds at a time.—Townsend W. Baer, M.D., Pittsburgh; Penn. Med. Jr., Vol. 48, No. 5, Feb., 1945.

# Recent Front Line Experiences in China

WESLEY L. FURSTE, II, M.D., Cincinnati, Ohio, Captain, Medical Corps, A.U.S.

SOME time ago, my medical unit, which was part of a United States Army field hospital, was running a small station hospital for sick Chinese. We had a suitable building, which had been used at one and the same time for a school and place of worship, to house our patients; were assisted by a few Chinese women nurses and a fairly large number of Chinese soldiers; and were getting good medical and surgical supplies from the United States and China.

The hospital was running very smoothly. But then suddenly and unexpectedly for us, the unit was alerted for immediate active field duty as a portable surgical hospital.

Within a few days, there were countless changes. Several officers and many men were shifted about among the various units of the field hospital. The Chinese nurses were assigned to other units, for we were told—and rightly so as we medical officers later found out—that they should not and could not endure the physical strain which was in store for us. We diminished greatly our total supplies on hand but increased markedly the percentage of surgical equipment. All officers and men were given the personal things required for the field.

Then came our movement orders. We bounced up and down rough mountain roads in Chinese trucks driven by Chinese drivers. Often, the roads were so high that we looked down upon the clouds over precipitous cliffs. Finally, we arrived at a place where we had to leave the trucks behind.

At this time, we were assigned by the Chinese Army some pack animals to move our equipment. We discovered that we had far too many supplies for the few animals allowed us; and were forced to send many items back to the supply depots. Even then, all of our small unit could not be moved at once; and it was transported forward in echelons.

For practically all of us, movement by animals over mountains was a new and not to be forgotten experience.

Our personnel had never before seen at close hand—much less walked over—the steep very high mountains that lay between us and the river which was our destination. But we set

out; and soon were able to walk up and down the narrow, rough trails for as long as 10 hours a day and with just two meals per day. Also we developed an admiration for the endurance of the Chinese soldiers in charge of our pack train and for their surefooted little animals which carried 80 to 120 pounds on their wooden saddles.

We found out by the difficult method of experience that the loads on these animals had to be well balanced. If they were not weighted correctly, the movements of the animals soon caused the frame for the loads to slip off the saddle, sometimes to roll down into a deep ravine from which the load had to be packed up by hand a piece at a time. We learned rapidly, however, to achieve adequate balance by the addition of one or several small rocks on the light side of the load.

Soon we reached a gray sandy beach by a rapidly flowing river where we had to treat many soldiers with wounds only a few hours old. We scattered ourselves on this beach; and under a clump of trees, set up an operating room.

For several days, one major surgical operation after another was performed. Traumatic injuries—such as a blown off lower extremity or an abdominal gun shot wound—which at home are the unusual became almost the commonplace. Since supplies were very precious, many of the surgical practices which are considered absolutely essential in the United States could not be carried out. For example, we did not wear operating gowns; and saved our few gloves for only abdominal, brain, and thoracic procedures.

Then, following the front lines, we moved forward in echelons across the river where I was temporarily attached to a U.S. line officer's liaison group. Within several days, this group began the ascent of a mountain range on its eastern side.

It is almost impossible to describe the ruggedness of the mountain trails over which we now moved and which rose to heights as great as 11,000 feet. At first, they were so precipitous that the pack animals were unable to ascend them; but gradually they were improved by engineer units so that the animals could travel over them. Since we were an advance unit, we were forced to leave the animals behind; and continued on with all our equipment carried on the backs of soldiers and coolies.

Frequently, the trails were beds of streams

This is a brief account of the experiences of a member of a unit, functioning as a portable surgical hospital, during a campaign in China. The intention is to give some information about how field surgical units work and live in China without divulging anything of military value. The writer hopes this point will be borne in mind if any readers find this description lacking in facts, details, and statistics. Only the personal views of the author are expressed.

Submitted December 15, 1944.



with cobble stones for footing so that slipping and falling were not uncommon. When a monsoon rain flooded these streams, it was necessary to wade through water as deep as a foot. Some of the trails were covered with black soil which turned to a sticky mud in the rain. It was not unusual for us to appear to have grown two or three inches in one day because we had that much mud clinging firmly to the bottom of our shoes.

Still other trails were of a slick clay composition which became responsible for a two-step-forward-one-step-backward snail-like progress uphill and a sudden roller-coaster effect on the descent, a misstep throwing the walker forward and making him gyrate wildly in an attempt to regain balance before he missed a curve and went over a cliff.

On account of the sheerness of the trails and the altitude with its low oxygen partial pressure, breathing became labored. We had to walk slowly, and often had to stop every several hundred feet of the path to "get our wind". After two days of such trails, we arrived just below the summit of the range. There we spent several cold rainy days with little sunshine.

Next, we went down the west side of the mountain range in about seven hours. Descent curiously enough, was almost as difficult as ascent. True, we did not experience the sensation of having our lungs splitting our chest; but we did develop knots in our calf muscles and knees which after about five hours of walking, felt like rubber.

Our new location was in a beautiful green productive valley where some of the natives had never before seen white men. After three days' stay, however, suddenly we went back up the mountain traveling in a pouring cold rain from midnight until noon. When we fell onto the ground that day at 6 P.M., it was the first sleep we had had in about thirty-six hours.

We spent several horrible days on that mountain top. We had very little to eat except rice, bamboo shoots, and a very small amount of canned U.S. rations; and we ate only twice a day because the food was so scarce and because it was so difficult to prepare. On account of the almost constant rain with the resulting high humidity, we had considerable difficulty in making the wet wood burn for cooking and keeping warm. When awake, I spent so much of the time close to the fire that my hands turned yellow by it. Our clothes were constantly damp. At night to keep warm, I wore an extra pair of socks which I wrung out just before putting on, in order to get rid of the water in them; and slept in short underwear, heavy long underwear, shirt, trousers, shoes, field jacket, and raincoat. In addition we slept with

one another; and put our heads under the damp blankets. In spite of all these clothes, I shivered about one-quarter of each night.

Next, we descended back down the east side of the range, i.e., the side we ascended first, into the warm river valley. During the descent, the trails were much worse on account of the continual rain of the preceding week. In some places, the mud was eight inches deep. Often, we didn't descend; rather, we slid down through the mud and slush.

Back in the valley, I received permission to go to a nearby town to have dental work done. After a five hour walk with a pack animal, I arrived at a recently prepared airstrip on the river. The following day, in a small liaison airplane, I flew to a rear echelon field hospital unit in twenty minutes over mountains that require three to four days to travel by foot.

Besides having my teeth taken care of, I delivered confidential papers to a headquarters; bought two hams, sausage, and red pepper to take back with me; obtained a large sum of money for our forces in the field; corrected our mail roster at the U.S. Army postoffice, sent EFM telegrams and mailed letters for those of my unit back in the mountains; and equipped myself with new clothing. Such are some of the odd tasks performed by a medical officer in addition to his strictly professional work. Then I was whisked back by airplane to the river airstrip; and walked to the headquarters I had left.

While waiting at the headquarters for an animal to move forward to join the headquarters surgical unit again, I nearly suffered a very serious accident. We had seen many supplies dropped by parachute; and we had lost our initial fascination of watching them being pushed out of the big transports and floating to the ground. One afternoon, after supplies had been falling for several hours, we ceased looking at them. Suddenly, an infantry lieutenant colonel shouted to me to run. I did. About one second later, a load of ammunition, weighing approximately 100 pounds, swiftly sailed by the exact place where I had been sitting. If I hadn't been warned, I could have been easily severely injured or killed by the parachuting ammunition.

After about a week's rest, I started back over that 12,000 foot mountain range which I had previously crossed.

This time, the crossing was still difficult on account of the deep mud and mire. Also, the bodies of dead pack animals which had been unable to keep going were seen en route; and were being rapidly devoured by thousands of actively, squirming, grayish-white maggots. The cold, damp climate at the crest did not seem so bitter this time, however, because we crossed the

range completely in four days, resting but one day en route.

In these trips over the mountains, the physical endurance of many of the Chinese were amazing. At times, we Americans, with no load but a weapon and a light musette bag, felt as though we couldn't keep going. The Chinese soldiers, however, with as much as 40 pounds on their backs, stayed with us; and were willing to continue marching.

During this first part of the campaign, most of us Americans lost 10 to 20 pounds. Practically all of us had enteritis or some other sickness, the most ill being flown back to rear medical installations. But the remainder of our stay in the field was to be far easier; and enabled us to regain our weight and strength.

In the pretty valley where we now found ourselves, we were able to locate a small village which appeared to be a good site for our hospital and living quarters. Within several days, we had our operating room built up; and were ready for casualties. But the enemy continued to retreat; and after a few weeks, without having received patients, we moved on, passing over some low mountain ranges and over another river by a swaying foot bridge.

Arriving at our new location, we found the enemy well fortified and firmly entrenched in a small town on an adjacent hill. Our fighting units had been moved so that the enemy was surrounded.

Several miles from the front line, we set up our hospital in a Chinese nunnery which proved to be the best site we had during the entire campaign. The several nuns there graciously gave over their living quarters and two places of worship and moved into a small section of the building. Incidentally they were very helpful in doing our laundry and sewing—a feminine touch which we had missed for many days.

In one place of worship, we had our operating room. There, our carpenter constructed two operating tables with the head lower than the foot to help combat the shock which so many of our patients exhibited. Also, he nailed boards to the tall pillars supporting the roof. From these were hung the bottles with the intravenous fluids administered during the operations. Adjacent to the operating tables, we found adequate space for our surgical instrument tables and for our expendable surgical supplies.

In the other place of worship, we had the ward which was provided with "beds" by the Chinese Army. These consisted of two wooden horses and about four wooden planks covered with a straw mattress, a small pillow, and one sheet.

Elsewhere in the nunnery, we found an ade-

quate number of beams which were sheltered from the rain and from which we were able to swing our jungle hammocks. During all of our front line experiences, we slept in these surprisingly comfortable, insect proof hammocks.

In another area of the nunnery, our cooks found already constructed ovens so that they had little trouble in setting up a kitchen. In this place, also, our water was boiled; and kept in a Lyster bag which was one of the most valuable pieces of light equipment we carried.

About 100 feet from the building, there was a clear spring divided into two parts by a stone wall. From one side, we were able to obtain all the water we needed for drinking, cooking and hospital purposes; and in the other side we took cold and invigorating sponge baths.

Leaving the front via litters or walking, the wounded passed through aid stations. From there, the serious casualties came to us; and the nonserious casualties, to a Chinese field hospital within a quarter of a mile of our nunnery hospital.

Throughout the entire campaign, we worked with this field hospital; and always picked our site within a short distance of it. The casualties who came to us were operated on; and, when they had recovered from the operation, were sent to the Chinese unit for post operative care and transportation to the rear.

One night, we heard more fire than usual at the front. About 11 P.M. we received word that the enemy was attempting to escape from the town and might be coming our way. All of us rose and stayed awake the rest of that night. What made our vigil quite gruesome was the pitch darkness and constant heavy rain which made it impossible to be aware of anyone approaching. When morning dawned, we learned much to our relief that the infantry had repulsed the attack and pushed the enemy back into the town.

After some time at the nunnery, we were relieved by another surgical unit. At the end of a four day foot trip over the same group of mountains and rivers, we arrived back at our field hospital headquarters.

While at the front, we saw most of the wounds produced by modern warfare. We were able to observe what happens to all parts of the body from the scalp to the toes when these parts are struck by small, medium, and large missiles. Our work has been unusually instructive in that we have treated these wounds at the front and are now able to see the results of such care at our semi-permanent hospital, through which casualties pass en route to the rear.

During our travels on this campaign, we passed through regions where there were supposed to be some quite characteristic pathological



conditions. The many colloid goiters which we saw were very large; were seen in many men and women and would have been real operative problems if we had removed any of them. Syphilis, gonorrhea, malaria, and enteritis were said to be frequently found among the natives; but not many cases were brought to us. One unfortunate newborn baby had all the classical signs of congenital lues. Trachoma in all its stages was a very common disease for which the people would seek our aid.

One of the greatest morale building functions of the supply channels of the campaign was the delivery of mail and Post Exchange items. These came by small liaison airplanes landing at airstrips constructed within several walking hours of wherever we were.

At first, we received mail only once every three or four weeks; but, then, much more regularly and frequently—sometimes as often as several times a week. Occasionally, we obtained letters which had been mailed from home only three weeks previously.

Overseas, the "P.X." rations are always looked forward to; and in the field, are almost as important as mail for keeping up morale. In the beginning of the campaign there was a small charge for them; but later they were distributed gratuitously. Highly desired were the three or four cartons of cigarettes and the several candy bars which arrived each month. Best of all was a supplementary ration which included among other articles, jungle knives, camera films, mocassins, playing cards, an excellent wrist watch, and cigarette lighters.

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### Mass Tuberculosis Surveys

New knowledge as to the effective use of chest X-rays and new methods greatly reducing the cost of large numbers of X-ray diagnoses put into our hands far more effective facilities than we heretofore had for the elimination of tuberculosis. It is now practicable to think in terms of X-raying the entire population of various areas, beginning perhaps with areas in which tuberculosis rates are still high. We can get rather definite estimates as to the number of cases which will be discovered in the various stages of the disease. We can formulate tentative estimates as to the additional number of hospital beds that will be required, and as to the numbers for whom partial or complete rest at home may be adequate. We can also judge as to the frequency with which such X-ray examinations will need to be repeated in any given locality, in order to catch the most recent infection.—Homer Folks, *Amer. Jour. P. H.*, Feb., 1944.

### Differential Diagnosis of Tuberculosis in Elderly People

While tuberculosis is relatively common in later life, its detection is frequently difficult. Diseases likely to cause confusion are frequently met. Included among them are cancer, cardiovascular disease, chronic bronchitis, emphysema, bronchiectasis, asthma and silicosis. If the sputum does not contain tubercle bacilli, the differentiation becomes increasingly difficult. Cough, weakness, loss of weight, hemoptysis and other symptoms found in tuberculosis may be present in other conditions with consequent difficulty in differential diagnosis.

Many cases of tuberculosis in older people are not detected because few of them have had chest X-rays. Most of the surveys have been among children and young people who are much more easily persuaded to cooperate. It has been difficult to secure the consent of older people for examination. They pay less attention than young people do to declining health, which they feel is to some extent inevitable. Their tired feeling they consider a normal accompaniment of old age. They do not like to change their environment and are fearful lest there may have to be radical alterations in their way of living. Inertia and dread of loss of security make them hesitate.

Methods of search for unsuspected cases of tuberculosis, however, are changing. The X-ray, our most valuable resource for this purpose, is being used more frequently since it is becoming less expensive. An X-ray of the chest will soon be part of the routine examination of all patients seen by physicians in their offices, just as it is now becoming a part of up-to-date clinic practice.—A. T. Laird, M.D., *The Journal-Lancet*, June, 1944.

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### Tinea Capitis

Our present chemical therapy for *M. audouini* infections is in the early experimental stage. All topical and internal medications used to date, in a large series of cases, have resulted in failure. The secret of a successful medicinal therapy for tinea capitis caused by *M. audouini* has not yet been found.

The patient who is infected with *M. lanosum* presents a much more hopeful picture. This type of infection persists for only one to three months, and shows a tendency to spontaneous cure. Treatment with an ointment containing 5 per cent ammoniated mercury or any other antiseptic, in a not too concentrated form, will result in a cure in a few week's time.—Townsend W. Baer, M.D., *Pittsburgh; Penn. Med. Jr.*, Vol. 48, No. 5, Feb. 1945.

# Man, Then the Gods

ALFRED J. ELKINS, M.D.

*Use human means as if there were no divine ones, and divine as if there were no human ones.—Balthasar Gracian.*

THE field of medicine is an unfortunate area for metaphysicians and cultists to explore, in order to propagate sentimental vagaries concerning the relationship between mind and body. Frequently, we find that only a little experimentation in the realm of known phenomena will demonstrate many fallacies regarded as scientific verities.

Let us take three frogs: In the first frog, we shall destroy both brain and spinal cord by inserting a wire probe at the base of the skull, and pushing it forward into the cranial cavity and then backward into the spinal column. In the second frog, employing in part the same technique, let us destroy only the brain. The third frog, we shall not mutilate in any fashion. For convenience, let us suspend the three animals from a ringstand attached by their lower jaws.

In the first frog, we note that in spite of the destruction of brain and cord, life's processes are taking place. Respiration, pulsation of heart, and movements of intestines are observed. If we stimulate this animal by immersing its legs in a glass of dilute acetic acid, we get no response. It becomes quite clear that this animal has lost every agency for protection and environmental adaption. We know that this frog is being kept alive by that unspecialized and primitive type of nervous tissue called the vegetative nervous system. Far down in the biological scale of life this simple structure is alone responsible for life, but contributes little to the adaptive powers of the animal; as a result, life is short unless the environment is constantly contributing all the needs of the animal. Such an environment would be considered 100 per cent perfect.

Examining the second frog, we observe the same manifestations of life as found in the first animal. In addition, we find that the second frog when stimulated contracts his legs and brushes away the acid. In this animal there is at work a nervous structure which was absent in the first frog. This is an automatic reflex-mechanism which involves the spinal cord its centers, and segmental nerves distributed to the various organs. Such an animal has a limited power of adaptation and protection. This animal is without inhibitory control of responses and also deprived of self-direction. An animal in such a

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state is capable of living in an environment that is not perfect, provided he finds a large amount of cooperation.

The third frog represents the normal animal; he has the anatomy and physiology of the first and second frog, and in addition a more highly specialized organ—a brain. When stimulated the frog responds with activity of every muscle in his body; he is not content until he gains his freedom, after which he hurriedly hops away to a safe retreat. With the other frogs, escape by their own efforts is impossible. This normal frog, with its cerebral, spinal, and vegetative nervous systems working conjointly, is the type of animal prepared to survive when the environment is most hostile.

## EPOCH OF OUR LIVES

It is interesting to observe that those phenomena exhibited in the mutilated and normal frogs are displayed at different periods in man's development. This observation is the fulfillment of the biogenic law, namely, that the development of the individual recapitulates the stages in the evolution of the race or, "ontogeny recapitulates phylogeny".

The human offspring lives approximately 280 days in its uterine environment. During this residence the development of the embryonic structure is identical with that of the first frog. In order that the progeny might live, the environment must be perfect, which happens to be true with the uterine abode of man, and where there is no discrepancy between desire and attainment. As in the case of the first frog, the vegetative nervous system is responsible for maintaining intra-uterine life.

At birth the individual may be compared with the second frog. The newly born infant is able to register and respond to stimuli, although coordination and other evidences of brain activity are deficient. His reactions appear to be automatic and, therefore, dependent upon the reflex nervous mechanism which dominates the early



months after birth. As the infant develops into the child, the brain takes over slowly the controlling power of all nervous mechanisms.

The period of childhood may be compared in conduct with that of the third frog. At this time responses are not as prompt as in infancy, but are better controlled and cover a larger field of expression. That all-important mnemonic function of the brain has been established, and upon this endowment the realm of endogenous impulses has begun to operate. As life grows older, the chief task of the brain is the manipulation of impulses and responses operating in the vegetative and cerebrospinal nervous systems. This juggling of forces—a function of brain cells—is mind, a resultant physico-chemical state sustained by the organism at any moment during a neurological operation.

#### MIND OVER MATTER

The therapeutic value of mental states on the progress of disease becomes an interesting theme for many strange and weird speculations. Especially among the laity do we find too often a hopeless indulgence in beliefs, which claim that certain mental attitudes (conditions of the soul) are capable of curing bodily ills. Such credulity precludes the most important activities of the mind—control and self-direction. It appears that mental states are more valuable for prophylaxis, but variable and often dangerous as curative agents. Observations reveal that once an unhealthy condition has been established, the important problem at hand is removal of the cause. A hopeful attitude is most desirable, but this alone acts only as a temporary tonic which has a restricted value. This failure which follows the act of trying to convert an irreversible pathology by psychic manipulations is well shown in the following case.

#### A SEEMING MIRACLE

A man was brought to the hospital in the terminal stage of Addison's disease. For two days he was in a semicomatose condition; death seemed imminent. The physician in charge knew nothing could be done to cure the victim. As a test experiment, the doctor decided to investigate the value of psychotherapy on this patient. Within hearing distance, the physician discussed with interns the patient's case, and spoke in glowing terms of a supposedly new remedy that would effect a cure. At first the patient was listless but soon he became interested; his eyes brightened and before the group left the ward he was sitting up in bed smiling. On the third day, to the astonishment of all, he was walking about the hospital and partaking of two servings at each meal. On the tenth day he was a subject for autopsy, having died after a sudden collapse.

The explanation of this patient's revival is simple. The adrenal glands are essential to life;

when they become crippled by disease, the inhibitory influence of the brain came into play in order to conserve the fragment of functional tissue as long as possible. This conservative move on the part of the organism resulted in the production of a state of quietude, which required of the glands the least expenditure of energy. When the patient heard such hopeful news he consciously released himself from the protection of the higher centers; as a result, the vegetative nervous system was free to act without control, and a severely crippled organ was allowed to operate to the point of exhaustion. Experiences of this type are often proclaimed by various cults as evidence of miraculous cures, following the event of deceiving one's self that nothing is wrong. If the physician had been able to remove the cause the release from restraint may not have been so costly.

The life of the modern physician is replete with astounding histories of primitive indulgence in the healing art. In nearly every case the error is always the same—failure to recognize and remove a harmful stimulus irrespective of origin. The ease with which mankind submits to this derisive subterfuge is, perhaps, accounted for in a heritage transported from a dismal past in which human achievements were few. The gods were sufficient.

#### Plasma Treatment of Mumps Orchitis

During the past month there occurred an outbreak of forty cases of mumps aboard ship. To the present five patients have developed orchitis. After reading a recent article on pooled plasma treatment of mumps orchitis it was decided to try this form of therapy on all five patients. Five hundred cubic centimeters on reactivated dried pooled plasma was administered intravenously as the initial dose. One patient received a second 500 cc. of plasma when meningitic signs and symptoms appeared. Results obtained might be described as excellent to dramatic. Four of the patients volunteered the information that the plasma gave them very quick relief. Not enough time has elapsed to determine if any patients will develop atrophy of the testicle.—Robert G. Smith, M.D., Columbus, Ohio; *Naval Med. Bull.*, Vol. 44, No. 1, Jan., 1945.

#### Obstetrical Society Elects

At the recent annual meeting of the Columbus Obstetrical Society the following officers were elected: Dr. S. J. Goodman, president; Dr. W. M. Silbernagel, vice president; Dr. Z. J. R. Holtenbeck, secretary, and Dr. Robert Daley, treasurer. A report was received from Columbus hospitals showing that there had been approximately 5,000 births in hospitals during the past year and that the maternal death rate had been less than two-tenths of one per cent.

# Cine-Bronchoscopy: Kodachrome Visualization of Bronchial Pathology\*

PAUL H. HOLINGER, M.D.

**B**RONCHOSCOPIC examinations are now made routinely to aid in the diagnosis and treatment of pulmonary disease. Such specular examinations of the body cavities may be recorded photographically for case studies and for teaching purposes. The simplest concept of this photography is the substitution of a camera for the operator's eye, recording the endoscopic procedure as it is being made.

The camera developed for this endoscopic photography<sup>1</sup> consists of a magazine loading 16 mm. camera, and an f2.7 three inch lens. Illumination of the small endoscopic field is obtained by directing the image of the ribbon of a ribbon filament projection lamp onto a 45 degree mirror which encroaches on the lumen of the endoscope. This type of axial illumination provides adequately the illumination essential to color photography. A specially constructed telescope inserted into the system permits visualization of the field being photographed not only during the finding, but also during the actual filming.

Photographically, the larynx, trachea, right upper, middle and branches of the lower lobe may be visualized, as well as the left upper and lower lobe bronchi with their principal bronchial divisions. Exposure of the important lingular division of the left upper lobe bronchus is occasionally possible. The physiological changes in the bronchi which take place with respiration are readily observed. These consist of lengthening and shortening of the bronchi with inspiration and expiration, and an increase and decrease in the diameter of the bronchi on inspiration and expiration.

## INFLAMMATORY DISEASES

The commonest bronchial disease is bronchitis. Bronchoscopically, the inflamed mucosa is seen to show the same changes noted in the mucosa of the nose in acute rhinitis, namely, swelling, hyperemia and an increase in secretion. Such secretions readily become purulent and surprising quantities of pus may be aspirated from a patient with suppurative bronchitis even though there is no demonstrable anatomic bronchiectasis. Bronchiectasis limited to one portion of the lung may be suggested by the large quantity of pus originating from a lobe or an entire lung, and

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by the bronchial edema, ulceration and stenoses associated with the disease.

Actual bronchiectatic dilatations themselves are rarely seen. A lung abscess, on the other hand, is characterized by the inflammatory involvement of a single branch bronchus leading toward the abscess cavity itself. Inflammatory edema and granulation tissue surround the bronchus leading to the cavity, frequently occluding it to retard drainage of the cavity.

Bronchial tuberculosis is the commonest of the specific inflammatory processes involving the bronchi. In its early stages the condition is simply an inflammatory thickening of the mucosa. This may break down to form superficial ulcerations, or, more typically, the caseous, necrotic ulcers with prolific granulation tissue. Tuberculomas or hilar glands rupturing into the bronchi are other manifestations of bronchial tuberculosis.

Asthma presents a very definite bronchoscopic picture. Actual bronchial spasm may be noted, but more characteristic is the extreme antero-posterior collapse of the bronchial walls seen during expiration and especially with coughing. This collapse suggests a marked weakening of the cartilaginous bronchial rings and is readily recorded photographically. Bronchial stenoses are frequently found in asthmatics; the ropy, thick secretions are an important part of the picture, and these may be seen bubbling through the stenotic areas on forced expiration to give the wheeze and coarse rales so characteristic of the physical findings in this disease.

## NEOPLASTIC DISEASES

Bronchial tumors indicate their presence by varying degrees of bronchial obstruction, by pul-

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Presented before the Section on Eye, Ear, Nose and Throat, Ninety-Eighth Annual Meeting, Ohio State Medical Association, May 2-4, 1944.



monary suppuration beyond the point of obstruction, and by hemoptysis. Benign tumors, bronchial adenomas, occur most frequently in women, and are usually found to be smooth, round obstructions, occasionally lobulated, which are rarely accompanied by infiltration of the surrounding bronchial wall. Other benign tumors such as papillomata, chondromas, osteomas, and polyps occur in the bronchi but are extremely rare.

Bronchogenic carcinomas present an unending variety of bronchoscopic pictures. They may be relatively smooth, or, in the other extreme, friable, soft and fungating in character. Some are discrete and localized while others are invasive, producing extensive ulcerating necrosis, and extreme destruction of the bronchial walls. Bronchial rigidity, vocal cord paralysis, and a rounded, thickened carina indicate mediastinal metastases.

In 80 per cent of cases the tumor can be visualized and tissue can be removed to establish the diagnosis histologically. Failure to obtain tissue in the other 20 per cent of cases may be due to bronchial compression by the extra-bronchial portion of the tumor proximal to its bronchial invasion, or it may be due to the rigidity of the bronchial walls caused by mediastinal metastases.

These bronchoscopic findings in themselves are important diagnostic criteria in the absence of the more conclusive microscopic evidence. If the tumor is too small, or is too far in the periphery to be reached bronchoscopically, negative findings may likewise be obtained. In such lesions one may occasionally see a small stream of blood leading to the branch bronchus involved, giving confirming evidence to the possible diagnosis of bronchogenic carcinoma. Not infrequently a paraffin section of this aspirated blood shows the presence of tumor elements.

#### FOREIGN BODIES

Bronchoscopy was originally devised for the removal of foreign bodies from the trachea and bronchi and foreign bodies are still extremely important factors in bronchial pathology. When placed in the bronchi of anaesthetized experimental animals they duplicate the problems encountered in the human. These problems have been photographed and by means of special bronchoscopes the actual removal of the foreign body with forceps may be seen. The various valvular mechanisms of bronchial obstruction are clearly demonstrated with motion pictures of the action of the foreign bodies in the bronchi.

#### SUMMARY

By means of Kodachrome motion pictures taken through the bronchoscope, the physiology and pathology of the trachea and bronchi may be studied. The bronchoscopic appearance of in-

flammatory lesions, bronchial neoplasms and foreign bodies in the bronchi is described.

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### Diabetes Tomorrow

Any consideration of the future for diabetes must be based upon the startling increase in the number of diabetics in the population. Three causative factors are clearly evident: (1) more intensive search for and discovery of cases by better methods, (2) the aging of the population, and (3) the prolongation of diabetic lives due to better treatment.

The outstanding change in the statistics of diabetes, which has come about through the use of insulin, in the fact that the average age of death among 7,222 fatal cases has risen from 44 to 64 years. This clearly means the abolition of death in young diabetic patients but also it means increased duration of life after the onset of diabetes. Indeed among this same group of fatal cases the average duration of life has increased from 4.9 years in the early years of this century to 13.7 years between 1940-1944. Now the expectation of life for a 10-year child developing diabetes based upon both fatal and living cases as calculated by the Metropolitan Life Insurance Company is 40 years. Prior to 1914 only two patients in 100 lived for 20 years with diabetes; now such patients are 10 times as frequent. The doctor who treats diabetes today therefore, must plan his treatment not merely for tomorrow, but for 20 years hence.

More significant still has been the discovery of an unexpectedly high incidence of diabetes in the selectees examined at the Induction Center in Boston. Dr. Blotner and Dr. Hyde found that among 45,650 Massachusetts selectees who were examined not merely by question and answer but by analyses of blood and urine, diabetes in this age group was from 3 to 5 times as frequent as it had been expected on the basis of the National Health Survey. If these figures are confirmed in other parts of the country and particularly if such careful examinations were really carried out in the older age groups, then the total number of diabetics in this country might really prove to be not 700,000 but 2,000,000.—Elliott P. Joslin, M.D., Howard F. Root, M.D., Priscilla White, M.D., E. Paul Sheridan, M.D., and C. C. Bailey, M.D., Boston; *Med. Annuals*, Dist. of Columbia, Vol. XIV, No. 2, Feb., 1945.



# Neurogenic Paralytic Ileus Due to Compression Of Splanchnic Nerves By Aneurysm\*

ETHELDRED SCHAFFER, M.D.

**Case History:** C.P., a white female, 69 years of age, was first hospitalized in November, 1935, at which time a left radical mastectomy was performed for carcinoma. The pathological report was partially differentiated adenocarcinoma of the breast. Sections of several regional lymph nodes revealed no metastatic tumor. On December 11, 1944, she was again admitted to the hospital complaining of increasing constipation with stools of small caliber for 2 to 3 weeks. She also had had pain in the left lower quadrant of the abdomen which radiated to the sacral region and down the left leg. She had noted some constipation for 14 years and was known to have had hypertension for 4 years.

**Physical Examination:** Temperature 38.3° C., pulse 100, respirations 25, blood pressure 150 systolic, 102 diastolic. The patient was a moderately obese, white, elderly female who appeared chronically ill. There was a cicatrix of the left anterior chest wall and the left breast was absent. The heart was slightly enlarged to the left, the heart sounds were of good quality and the rate was regular. The abdomen was slightly distended and there was marked tenderness in the left lower quadrant where an indefinite mass could be felt. Rectal examination revealed a large fecal impaction. There was tenderness over the lower lumbar spine.

**Laboratory Examination:** Blood—10,200 WBC, 3.12 M. RBC, Hgb. 73 per cent (Sahli), urea nitrogen 9 mg. per 100 cc., plasma chlorides 95 m.eq. (555 mg. per 100 cc.), Kline exclusion test negative. Urine—slight trace of albumin and a few white blood cells in the sediment.

**Treatment** was directed toward the removal of the fecal impaction. Following this she continued to have a low grade fever and pain and tenderness in the left lower quadrant. Two proctoscopic examinations were attempted without success. The abdominal distension increased and on the fourth hospital day a Miller-Abbott tube was passed. By the seventh hospital day it had advanced to the terminal ileum, without relief of the distention. Roentgenograms following a barium enema on the eighth hospital day revealed multiple diverticula of descending and sigmoid colon, but no tumor or obstructive lesion.

Throughout hospitalization the patient complained of considerable abdominal and back pain. She was nauseated much of the time but did not vomit. Early on the morning of her ninth hospital day the patient's temperature rose rapidly to 39.6° C. She became dyspneic, cyanotic and apprehensive. Her pulse increased to 150 and the systolic blood pressure fell to 102. Dullness and rales were noted in the lower lobe of the left lung. Five grams of sulfadiazine were given and she was placed in an oxygen tent. She died 8 hours later.

**Final clinical diagnoses** were: hypertensive cardiovascular disease; left radical mastectomy; bronchopneumonia; paralytic ileus with probable intestinal obstruction.

## AUTOPSY

At autopsy (8652), 6 hours after death, the stomach and the intestines showed marked dilatation. It was estimated that the stomach occupied approximately one-third of the abdominal cavity. It filled the left upper quadrant and extended inferiorly to the level of the umbilicus and laterally into the right upper quadrant. The small intestine was greatly dilated to within 25 cm. of the ileo-cecal valve. A Miller-Abbott tube was in position and extended to this level. The distal portion of the ileum and the colon were collapsed and empty except for a large mass of barium in the rectum.

The other significant anatomic observations were: Marked arteriosclerosis of the aorta with saccular aneurysm of the upper abdominal portion with rupture and recent hemorrhage in the greater and lesser peritoneal cavities (100 cc. and 300 cc. respectively), erosion of the second and third lumbar vertebrae, and compression of the esophageal and celiac plexuses; atelectasis of the lower lobes of the lungs and slight chronic interstitial pneumonitis; cardiac hypertrophy and dilatation (380 grams); marked arteriosclerosis of the coronary arteries with stenosis, and chronic rheumatic endocarditis with mitral stenosis. An incidental observation of interest was a malignant carcinoid of the distal portion of the ileum, with invasion of the adjacent fat and metastases to the regional lymph nodes.

The thoracic portion of the aorta was slightly dilated and approximately three-fourths of its intimal surface was covered by irregularly shaped, slightly elevated pale gray and light yellow plaques. In the abdominal portion of the aorta there was a saccular dilatation measuring 13 cm. in circumference, extending from the level of the diaphragm to 1 cm. above the ostia of the renal arteries. The celiac and superior mesenteric arteries arose from the inferior half of the anterior surface of the aneurysm.

## COMMENT

The two most common causes of saccular aneurysms of the abdominal aorta are syphilitic mesoaortitis and arteriosclerosis. There was no evidence of syphilitic mesoaortitis in this case and since arteriosclerosis was marked in all portions of the aorta it is considered as the causative factor of the saccular abdominal aneurysm.

A review of the literature on syphilitic and arteriosclerotic aneurysms of the abdominal aorta reveals considerable disparity in the reported incidence. This variation might be accounted for by variations in hospital populations, criteria

\*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the twenty-sixth of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems".



used in establishing a diagnosis and small series of cases from widely scattered localities.

In Hubeny and Pollack's<sup>1</sup> series of 48 cases of abdominal aortic aneurysms at Cook County Hospital, Chicago, Illinois, 75 per cent were syphilitic by serology, history or anatomic observations. However, they conclude that syphilis as a cause of abdominal aortic aneurysm is more common in negroes and in patients up to the sixth decade and that arteriosclerosis occurs as the etiological factor more frequently in the white race and in the older age groups. Karsner<sup>2</sup> states that probably one-half of the abdominal aortic aneurysms are arteriosclerotic.

The carcinoid in the distal portion of the ileum was not of sufficient size to cause obstruction and there were no other lesions of the intestines other than the colonic diverticula, none of which was inflamed. In the absence of demonstrable mechanical obstruction it is reasonable to assume that the obstruction was neurogenic. The ostia of the celiac and superior mesenteric arteries were located in the anterior wall of the aneurysm and it is conceivable that the ganglia of the splanchnic nerves located in this region were subjected to pressure as the aneurysmal sac increased in size. Irritation of these ganglia would result in hypotonicity and decreased peristalsis of the bowel.

Microscopic examination of these structures revealed slight degeneration of a few of the nerve fibers and fibrosis of the nerve sheaths. The branches of the vagus nerves were so situated as to be subject to pressure by the upper portion of the aneurysmal sac. Stimulation of these nerves would result in contraction and increased motility of the stomach and intestine. Since dilatation was present it seems probable that there was no noteworthy pressure on the branches of this nerve.

Paralytic ileus has been described by Karabin<sup>3</sup> as an invariable accompaniment of retroperitoneal hemorrhage resulting from rupture of abdominal aortic aneurysms, trauma to the kidneys and compression fractures of the lower thoracic or upper lumbar vertebrae. He cites 7 cases of his own and a number from literature that had symptoms simulating acute peritonitis and who developed paralytic ileus following rupture of an abdominal aneurysm. Altmeier and Wadsworth<sup>4</sup> produced relaxation and cessation of movement of the small intestine experimentally by stimulation of the splanchnic nerves. Rupture in this case probably occurred after paralytic ileus had developed but the location of the aneurysm could account for pressure effects similar to those produced by hemorrhage in this region.

In reviewing the clinical course of this patient it is thought that failure of the Miller-

Abbott tube to reduce the intestinal distention should have suggested the possibility that mechanical obstruction was not the causative factor. Two findings which, in retrospect, were significant were pain in the left lower quadrant which radiated to the spine and down the left leg and tenderness in the lumbar area.

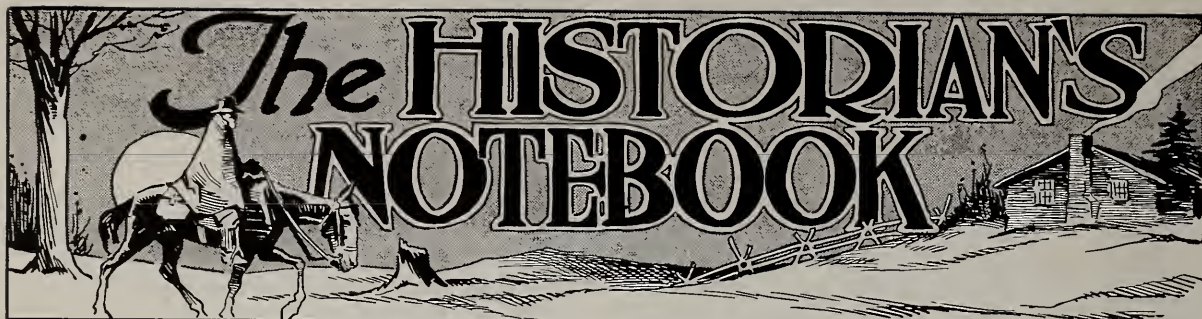
The obesity of the patient, the location of the aneurysm and the degree of abdominal distention would have made it practically impossible to feel a pulsating mass of this size in the epigastrium. It also would probably have been impossible to demonstrate this aneurysm by roentgenograms as there was little calcium in the wall of the aneurysm, though there was considerable calcium elsewhere in the aorta. The erosion of the lumbar vertebrae was probably obscured by gas shadows within the stomach and bowel. Had an aneurysm been suspected "coned down" or lateral view films might have demonstrated the bone destruction.

The immediate cause of death in this patient is difficult to explain. The blood loss did not exceed 400 cc. This amount in a patient with a red blood cell count of 3.12 M. is not sufficient to cause fatal anoxemia. The efficiency of the heart action was no doubt impaired by the changes present in that organ, which consisted of a deformity of the mitral valve with slight stenosis, marked coronary atherosclerosis and fat infiltration of the myocardium. In addition there was partial atelectasis of the lungs secondary to the marked dilatation of the stomach and small intestine. A combination of these factors may have been responsible for her death.

The absence of tumor like that of the carcinoma of the breast indicates that she was cured by the operation performed in 1935. The presence of a malignant carcinoid in the ileum raises the academic question of multiple malignant tumors in one person. According to Karsner carcinoids are a form of hamartomas developing from misplaced argentophil cells which normally occur principally in the distal ileum and the appendix. These lesions are generally benign but this one was both invasive and metastasizing. Cytologically the cells of this tumor are uniform in size and show none of the pleomorphism characteristic of malignant tumors in general. It would appear that neoplasia is not a local phenomenon but that there is some general factor, genetic or constitutional, which favors neoplasia.

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Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## Medical Curiosities—Oxygen Therapy, 1887

RALPH M. WATKINS, M.D.

TO think back, the writer recalls that, some 20 years ago, a weak concentration of chlorine gas was used in the treatment of some acute or chronic respiratory diseases. Patients were supposed to breathe this gas for a few minutes, and, behold, their infections were cured. An institution with which I was connected at that time, fitted up a room for this purpose but soon gave it up, for it did not work.

We may remember, further, a gadget widely sold about that time, which was to be installed in homes, offices or public buildings. An open, continuous electric spark caused some ozone to be freed and adding this to the room atmosphere theoretically was beneficial; however, it did not do much good in purifying the air, either, so it was soon discarded.

Then, some 30 or 40 years ago, there was quite a popular apparatus sold to be used in illnesses such as acute respiratory disease. This machine generated certain medicated fumes and perhaps performed somewhat the same task as an ordinary croup kettle, but was sold at a fancy price. Years ago, some of the older doctors told me of it.

Therefore, recalling these facts, I was not so much surprised to find that 60 years ago oxygen, in itself, or combined with nitrous oxide, was considered a sovereign remedy for many ills; and I am not by any means referring to the  $O_2$ - $ON_2$  mixtures as used today in anesthesia; then it was used in therapeutics.

### THE USE OF OXYGEN

A curious old volume, a book of 149 pages, "Oxygen in Therapeutics", by C. E. Ehinger, published in 1887 by W. A. Chatterton and Co., Chicago, has brought all this to mind.

### The Author

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Apparently a good deal had been written about the use of oxygen in treatment before that time for Dr. Ehinger referred to a number of articles. To check this, I looked up the subject in another old book, "Materia Medica and Therapeutics", by Roberts Bartholow, 4th Edition, 1883, and found the use of oxygen advised in dyspnea, asphyxia, gas poisoning, etc., as we would use it now—but also in some diseases of insufficient oxidation such as chlorosis, anemia, leucocythemia, diabetes, albuminuria. And Bartholow, a professor in Jefferson Medical College, was an authority of his day. The treatment must have been widely used and recognized.

It is unnecessary to go into detail with a good deal of it, especially the first pages which deal with the properties and distribution of oxygen. He next talks of its preparation. The simple method of heating potassium chlorate in the presence of manganese dioxide was commonly used.

Apparently, while one could buy the gas in tanks, it was expensive and the better way was to make one's own by installing suitable apparatus. After the gas had evolved it was stored in gasometers, over water, and drawn off as needed. It could be transported in rubber bags to a person ill at home.

I judge these treatments were given without any check on oxygen concentration in the blood. Nothing is said of that. In those days, if some



agent made a patient feel better, it was good and useful—rule of thumb method. As a matter of fact, it is probable that any increased concentration in the blood obtained was of short duration and of little therapeutic value.

For home treatment, also, one could make his own oxygen by gently heating hydrogen peroxide.

#### PHYSIOLOGY

The chapter on the Physiology of Oxygen seems very crude but probably summarized the knowledge of the day.

Before going further and bringing in the subject of nitrous oxide, it seems worth while to report one or two sidelights of this oxygen therapy.

Oxygen inhaling became very popular, almost a parlor sport, something like the early days of ether. It became so popular that in the large cities, New York, for example, there were "oxygen parlors" widespread, not run necessarily by doctors but by those who were looking for easy money; in these places, for a fee, one could stop and inhale oxygen for a certain time, as often as desired. They became so common for a time that the doctors protested their presence. One now can say that, at least, they did no harm.

Another money-making practice began: Manufacturers sent agents to doctors all over the country to sell them apparatus necessary for the making of both oxygen and nitrous oxide. The same machine would make either gas, but the nitrous oxide was so simple to prepare, (merely by heating ammonium nitrate), that it was not nearly mysterious enough; therefore, to make money, the manufacturers called nitrous oxide, "Compound Oxygen", adulterated the ammonium nitrate with something inert, and sold it for a fancy price.

Dr. Ehinger devotes a chapter to disclaiming such a substance as compound oxygen and clears the air in that regard.

#### TREATMENT

He then goes into treatment methods. The patient should be treated in the office, once, or perhaps, twice a day. He was supposed to fill his lungs with the gas as deeply as possible, but to inhale it only once in five minutes. The patients must not come in hurriedly or leave thus but should rest after the course. Rooms should be cheerful. Several people could be treated at once. They should stand erect. The amount given was gradually increased.

As an anesthetic, nitrous oxide, of course, had been used for many years, since the 1840's. But it was commonly used as described above, in 1887, as therapy, mixed with oxygen. Taking such an inhalation once in five minutes naturally would not have an anesthetic effect, but would

certainly give the patients a momentary feeling of exhilaration.

Dr. Ehinger advises the profession not to spurn accessory treatment for the diseases and especially recommends the free ingestion of water and frequent bathing.

Perhaps the most interesting part of the book deals with therapeutic indications. He relates many case histories in great detail. It will be sufficient, in the interests of brevity, merely to record the diseases which were treated by inhalation of oxygen or nitrous oxide or both: Asthma, bronchitis, capillary bronchitis, reflex cough, croup, diphtheria, pulmonary emphysema, pneumonia, phthisis, (not the advanced form—there was danger of hemorrhage), dyspnea, indigestion and headache, albuminuria, diabetes, spermatorrhea, rheumatism, gout, insomnia, cholera, anemia, leukemia (cured this patient), chlorosis, asphyxia and poisoning, puerperal eclampsia, uremia, tetanus (relief only!), hydrophobia (cured!), hysteria, epilepsy, neuralgia, paralysis, neurasthenia, pelvic cellulitis, fatty placenta, menstrual irregularities, vomiting of pregnancy, chronic pyemia, septicemia and ulcers.

\* \* \* \* \*

This ends the book, as it might well do. It is no cause for wonder that gas inhalations were so popular after such glowing testimonials. I suspect that later on it was determined that most of the diseases treated and cured, would have been cured by other and simpler measures.

Again, here is another therapeutic method which today has assumed its rightful niche.

It is amusing for us to read of the enthusiasms of the old days, but a little sad too. It is a pity that so many did not last, with so much time and thought expended on them. However, we advance by trial and error. Some of our present-day enthusiasms won't last too long, either—I hope.

#### Resistance to Tuberculosis

Most of the tuberculous patients who seek medical aid today have had many reinoculations with many resultant foci of varying degrees of severity. The best that clinicians can do in a short course of treatment in such a chronic disease is to secure a truce between the patient and his bacilli, a truce which may be broken on either side: by the bacilli if their environment becomes congenial for their growth and multiplication; by the patient if he can increase his resistance sufficiently, maintain it at a high level, and thus prevent the bacilli from further activity.—Tuberculosis Abstracts.

# Western Reserve University Picks Dr. Joseph T. Wearn As Dean of Medical School, Succeeding Dr. Sollmann

**D**R. JOSEPH T. WEARN, professor of medicine at Western Reserve University, Cleveland, since 1929, has been appointed Dean of the University's School of Medicine. He succeeds Dr. Torald H. Sollmann, who retired as



DR. WEARN

Dean last July 1, after nearly 50 years of service with the University. The new Dean will continue as professor of medicine and as director of the department of medicine at Lakeside Hospital.

Widely known as a teacher in his field and for his research in medicine, the chief research work of Dr. Wearn has been in the physiology of heart disease, and in the diseases of the blood, including leukemia. He has written extensively on these subjects.

Dr. Wearn is also a consultant to the Surgeon General of the United States Army, consultant to the research and development branch of the Office of the Quartermaster General of the U. S. Army, chief of the division of physiology, Committee of Medical Research and chairman of the subcommittee on blood substitutes, of the Office of Scientific Research and Development.

## FORMERLY AT HARVARD

He came to Western Reserve and Lakeside Hospital in his present capacity in 1929 from the Harvard Medical School where he was associate professor of medicine and associate director of the Thorndike Memorial Laboratory and visiting physician at Boston City Hospital.

Born in Charlotte N. C., on February 15, 1893, Dr. Wearn was graduated from the Charlotte University School and in 1913 was awarded the degree of Bachelor of Science from Davidson College. He received his degree of Doctor of Medicine from Harvard in 1917. Davidson College also granted him an honorary degree of doctor of science in 1943.

## MEMBER OF MANY SOCIETIES

He is a member of the Ohio State Medical Association; fellow of the American Medical Association; member of the Association of American Physicians, the American Academy of Arts and Sciences, the American Society of Clinical Investigation, the American Climatological and Clinical Association, the American Physiological Society, Phi Beta Kappa, Alpha Omega Alpha and

Sigma Xi fraternities. He was secretary of the Association of American Physicians from 1943 to 1945, and president of the American Society for Clinical Investigation in 1935.

Regarding his new position, Dr. Wearn commented that "very important changes are taking place in medical education today and a great amount of thought is being given to improving the form of medical care which the public receives. The School of Medicine at Western Reserve has always been deeply interested in the subject of medical care for it has an important bearing upon our methods of teaching. The direction which the form of medical care takes in the United States is vital to medical education."

## Opening for Physician in Maternal and Child Health Program

Physicians interested in a new position having to do with the development of the maternal and child health program of the Ohio Department of Health and meeting the qualifications established by the Ohio Civil Service Commission for the position should write to the Ohio Department of Health.

Typical duties of such official would be: To assist or act as consultant to local health departments in the development of maternal and child health services or facilities; to inspect maternity hospitals and advise regarding improvements in organization and procedures; to assist in organizing and to serve as examining physician at child health conferences; to maintain records and prepare reports; to conduct institutes for public health nurses on maternal and child health subjects; to lecture to professional and lay groups on various aspects of maternal and child health and to prepare articles on these subjects; and to perform other related duties as required.

Qualifications established for the position are:

- (1) Graduation from an approved school of medicine,
- (2) One year's internship, and
- (3) At least one year of graduate training, plus one year of training or experience, in clinical pediatrics or obstetrics. (It is desirable that the applicant have had experience in the field of maternal and child health.)

(4) Must have a license to practice medicine in the State of Ohio, or be eligible for licensure through endorsement.

(Note: It is desirable that the applicant have had training in the fundamentals of public health.)

Salary schedule for the position is \$300.00 per month, and up.



# Physicians Under 38 Affected by New Selective Service Procedure Relative to Deferment of Essential Men

**S** ELECTIVE SERVICE has revised its procedures relative to the deferment of men under 38 years of age, including physicians. Text of an official announcement on this matter was published on page 596 of the March 10 issue of *The Journal of the A.M.A.* Publication of information on this in *The Ohio State Medical Journal* has been authorized by Ohio Selective Service Headquarters and Dr. Robert Conard, Ohio chairman, Procurement and Assignment Service for Physicians.

All physicians through age 37, **exclusive of those classified by Selective Service as 4-F or those holding commissions in the Army or Navy reserve corps**, who are now in an essential classification (2-A or 2-B), are affected by this new procedure. This includes teachers in medical schools, physicians employed by industry and by hospitals (salaried heads of X-ray, anesthesia or laboratory departments), interns and residents, and physicians engaged in private practice.

If essential physicians through age 37 **who are not commissioned or classified 4-F** are to be continued in a deferred classification under Selective Service, it will be necessary for them or their employer to comply with the following procedures:

## A. LIST OF ESSENTIALS REQUIRED:

1. Employers (medical schools, hospitals, industries, etc.) should submit the names of all essential physicians under 38 years of age to Dr. Robert Conard, chairman, Ohio Procurement and Assignment Service for Physicians, 79 East State Street, Columbus 15, Ohio, together with date of birth, explanation as to why the physician is considered essential, and the physician's present Selective Service classification.

## B. PHYSICIANS 18 THROUGH 29 YEARS:

1. In the case of an employed physician in the age group, 18 through 29 years, **except those who hold a commission or who are classified by Selective Service as 4-F**, two completed sets of three copies each of Selective Service Form 42-A (special revised) should be submitted to Dr. Conard so he can properly certify on the form that the physician is essential, if he is so classified by Procurement and Assignment Service, and transmit the form to the physician's Local Selective Service Board.

2. Physicians in the age group 18 through 29 years who are engaged in private practice, **except those who hold a commission or who are classified by Selective Service as 4-F**, should submit to Dr. Conard two completed sets of three copies each of Selective Service Form 42-A (special revised) for handling as described above.

## C. PHYSICIANS 30 THROUGH 37 YEARS:

1. Physicians in the age group 30 through 37 years **who are engaged in private practice or employed, except those who hold a commission or who are classified by Selective Service as 4-F**, should confer immediately with their Local Selective Service Board on this matter and should follow the advice of the Board as to the necessity for filing Forms 42 or 42-A with Dr. Conard. If the board advises that forms should be filed, two completed forms 42 or 42-A should be transmitted to Dr. Conard at once.

## D. WHERE TO GET FORMS:

The Selective Service Forms referred to (42, 42-A, or 42-A, special revised) may be obtained by the employer or physician from State Selective Service Headquarters, 40 South Third Street, Columbus 15, Ohio.

The procedures outlined above, as stated, do not affect physicians officially classified by Selective Service as 4-F or those who hold commissions in the Army or Navy reserve corps, but do affect all other physicians in the age group 18 through 37.

# Write Senators Taft and Burton To Support Senate Bill 637, A Bill To Provide Deferments for Adequate Number of Premedical and Medical Students!

**O**HIO PHYSICIANS should communicate with United States Senators Robert A. Taft and Harold H. Burton immediately, requesting them to support Senate Bill 637 now pending before the Committee on Military Affairs of the U. S. Senate.

Senate Bill 637, introduced by Senator Allen J. Ellender, Louisiana, includes provisions for the deferment of adequate numbers of premedical students for a period of two years and further provides for the deferment of such numbers of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes in medical schools.

## SUPPORTED BY OFFICIAL GROUPS

The proposal has the support of the American Medical Association, the Council on Medical Education and Hospitals of the A.M.A., and the Executive Committee of the Association of American Medical Colleges.

Action by various local medical societies in support of the bill and transmittal of such action to Senators Taft and Burton also is suggested.

Commenting on the proposal, the reasons for its introduction and how its passage by the Congress would alleviate a critical problem relating to a shortage of premedical and medical students, *The Journal of the American Medical Association* stated in its March 10 issue:

## REASONS FOR BILL OUTLINED

"The Council on Medical Education and Hospitals of the American Medical Association has repeatedly urged the necessity for changes in the present policies of governmental agencies, including the Selective Service System, having to do with the education of premedical students. The regulations now in force threaten either a reduction in freshmen enrollments or a far poorer quality of students in late 1945 and 1946.

"The House of Delegates of the American Medical Association at its meeting in Chicago in June, 1944, took official cognizance of the seriousness of this problem and addressed communications to the President, to the War and Navy departments and to the Selective Service System urging that immediate steps be taken to remedy the situation.

"Now official notice of this threat to medical education and medical standards has been taken by Senator Allen J. Ellender of Louisiana, who introduced on February 26 Senate Bill 637, which has been referred to the Committee on Military

Affairs and which is printed in full elsewhere in this issue.

"The bill includes provisions for the deferment of adequate numbers of premedical students for a period of two years and further provides for the deferment of such numbers of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes. The bill also calls for the return to medical and premedical studies of qualified members of the armed forces who have honorably served for a year in the military forces. The latter provision may require some clarification, especially as regards the selection of students for this type of training.

## CRITICAL SHORTAGE SEEN

"At the time of introducing his bill, Senator Ellender pointed out that the discontinuance of the Army Specialized Training Program and the Navy V-12 Programs would, with a few exceptions, result in the cessation of the admission of new students to the freshmen classes of 1945 in the medical and dental schools.

"This is a manpower problem of the present moment, he said, only because a critical shortage of doctors and dentists after 1948 must be anticipated and can be prevented only by action taken now, before September, 1945. The Army and Navy medical corps are certain to need more physicians after the war than were required before this war started; the Veterans' Administration will demand eight or ten thousand doctors; physicians will be required to administer the features of the compulsory military training program if that should be provided by Congress and an unknown number of doctors may be wanted to provide the most basic needs of the now occupied countries of Europe, where no medical education has been possible for five or more years.

"All these requirements are likely to result in a greater deficit of medical men than ever before. The profession is being depleted by about four thousand deaths and an unknown number of retirements annually, Senator Ellender said, and this picture will add up to a very serious situation unless a continuous flow of medical student graduations is maintained annually.

"The main outlines of this bill are fully endorsed by the Council on Medical Education and Hospitals of the American Medical Association and the Executive Council of the Association of American Medical Colleges."



# Funds for Research To Be Sought by Cancer Field Army In Annual Membership Campaign in Ohio in April

By LAWRENCE A. POMEROY, M.D., Cleveland, Ohio

Chairman, Executive Committee, Ohio Division, Field Army, American Cancer Society, and  
Member, Committee on Public Health Education, Ohio State Medical Association

SINCE its inception in 1913, the American Society for the Control of Cancer has served as a clearing house for the exchange of information on cancer. During the first twenty-three years of its existence, it devoted itself mainly to making available to all physicians the facts known about cancer.

In 1936 the Society decided it was time to attempt public education so that patients would be able to recognize the broad symptoms of cancer and present themselves for medical examination and treatment in the early stages of the disease when the percentage of cases that might be cured is much higher.

The Women's Field Army was formed for the purpose of carrying on the work of public education. It was established in 47 states and has done an excellent job in telling the public the general facts about cancer.

### RESEARCH FUNDS SOUGHT

In 1944 the American Society for the Control of Cancer came to the conclusion that another step forward was necessary. There was apparent a great need for establishing a central agency to study the needs in cancer research and to provide funds for such research.

In order to make itself available as the foundation for such services, the American Society for the Control of Cancer enlarged its articles of incorporation and at the same time changed its name to The American Cancer Society. The name of the Women's Field Army was changed to The Field Army at the same time, in recognition of the need for bringing more men into the society.

The American Cancer Society has decided it will attempt this year an extensive campaign for public contributions, part of which will go to a pool to support research.

In Ohio, Mr. Richard L. Kroesen, Cleveland, has been appointed as State Campaign Chairman. Mr. Kroesen is also State Campaign Chairman for the National Foundation for Infantile Paralysis and in that capacity is well known to the Ohio medical profession. He will work with Mr. Eric Johnston, President of the U. S. Chamber of Commerce, who is the American Cancer Society's National Campaign Chairman.

The American Cancer Society will not itself engage in research but it will have a five-man committee which will receive and study appeals

### Editor's Note:

The Journal considers it a privilege to publish the accompanying article by Dr. Pomeroy relative to the activities and aims of the Ohio Field Army, American Cancer Society. The organization will hold its annual membership campaign during the month of April. It deserves the active support and cooperation of the medical profession as well as the public generally.

for funds to carry on research. It will grant funds for as long a time as may be necessary to complete a line of inquiry and it is anticipated that an individual, a laboratory or a university will be eligible to receive grants. The members of the National Committee are: Dr. Clarence C. Little, Dr. Florence Sabin, Dr. Charles Huggins, Dr. E. W. Goodpasture, and Dr. James B. Murphy.

National conferences on special phases of the cancer problem, similar to the one on parental influence reported by Waldemar Kaempffert in the *Saturday Evening Post* of February 17, 1945, are expected to be held regularly. At the parental influence conference held at Bar Harbor in September, 1944, forty-one participants discussed and agreed upon a program for future analysis and outlined the specific types of questions to be answered for each case analyzed.

The accompanying tables of Ohio cancer statistics for the years 1942 and 1943 from the Ohio Vital Statistics Report, Ohio Department of Health, show clearly how important it is to do everything possible in Ohio to combat cancer.

### OHIO CANCER DEATHS

| County     | 1940 Population | Cancer 1942 | Deaths 1943 |
|------------|-----------------|-------------|-------------|
| Adams      | 21,705          | 24          | 16          |
| Allen      | 73,303          | 121         | 110         |
| Ashland    | 29,785          | 31          | 43          |
| Ashtabula  | 68,674          | 110         | 95          |
| Athens     | 46,166          | 35          | 42          |
| Auglaize   | 28,037          | 32          | 33          |
| Belmont    | 95,614          | 127         | 95          |
| Brown      | 21,638          | 16          | 15          |
| Butler     | 120,249         | 149         | 150         |
| Carroll    | 17,449          | 23          | 19          |
| Champaign  | 25,258          | 42          | 36          |
| Clark      | 95,647          | 130         | 127         |
| Clermont   | 34,109          | 44          | 49          |
| Clinton    | 22,574          | 22          | 32          |
| Columbiana | 90,121          | 107         | 115         |
| Coshocton  | 30,594          | 31          | 37          |

| County     | 1940 Popu-<br>lation | Cancer<br>1942 | Deaths<br>1943 |
|------------|----------------------|----------------|----------------|
| Crawford   | 35,571               | 40             | 64             |
| Cuyahoga   | 1,217,250            | 1,904          | 1,952          |
| Darke      | 38,831               | 59             | 44             |
| Defiance   | 24,367               | 35             | 36             |
| Delaware   | 26,780               | 36             | 42             |
| Erie       | 43,201               | 68             | 71             |
| Fairfield  | 48,490               | 53             | 54             |
| Fayette    | 21,385               | 24             | 36             |
| Franklin   | 388,712              | 658            | 689            |
| Fulton     | 23,626               | 30             | 41             |
| Gallia     | 24,930               | 33             | 41             |
| Geauga     | 19,430               | 19             | 19             |
| Greene     | 35,863               | 38             | 39             |
| Guernsey   | 38,822               | 53             | 48             |
| Hamilton   | 621,987              | 1,084          | 1,115          |
| Hancock    | 40,793               | 57             | 50             |
| Hardin     | 27,061               | 49             | 49             |
| Harrison   | 20,313               | 23             | 16             |
| Henry      | 22,756               | 27             | 22             |
| Highland   | 27,099               | 24             | 33             |
| Hocking    | 21,504               | 21             | 23             |
| Holmes     | 17,876               | 23             | 14             |
| Huron      | 34,800               | 49             | 57             |
| Jackson    | 27,004               | 34             | 22             |
| Jefferson  | 98,129               | 80             | 100            |
| Knox       | 31,024               | 38             | 44             |
| Lake       | 50,020               | 57             | 55             |
| Lawrence   | 46,705               | 59             | 47             |
| Licking    | 62,279               | 82             | 84             |
| Logan      | 29,624               | 46             | 51             |
| Lorain     | 112,390              | 133            | 163            |
| Lucas      | 344,333              | 526            | 547            |
| Madison    | 21,811               | 20             | 17             |
| Mahoning   | 240,251              | 282            | 309            |
| Marion     | 44,898               | 53             | 53             |
| Medina     | 33,034               | 50             | 46             |
| Meigs      | 24,104               | 18             | 24             |
| Mercer     | 26,256               | 43             | 57             |
| Miami      | 52,632               | 71             | 59             |
| Monroe     | 18,641               | 18             | 15             |
| Montgomery | 295,480              | 419            | 464            |
| Morgan     | 14,227               | 11             | 14             |
| Morrow     | 15,646               | 18             | 20             |
| Muskingum  | 69,795               | 86             | 108            |
| Noble      | 14,587               | 20             | 11             |
| Ottawa     | 24,360               | 35             | 30             |
| Paulding   | 15,527               | 16             | 15             |
| Perry      | 31,087               | 31             | 36             |
| Pickaway   | 27,889               | 20             | 23             |
| Pike       | 16,113               | 18             | 9              |
| Portage    | 46,660               | 57             | 77             |
| Preble     | 23,329               | 27             | 19             |
| Putnam     | 25,016               | 31             | 22             |
| Richland   | 73,853               | 98             | 105            |
| Ross       | 52,147               | 54             | 52             |
| Sandusky   | 41,014               | 47             | 46             |
| Scioto     | 86,565               | 98             | 77             |
| Seneca     | 48,499               | 64             | 75             |
| Shelby     | 26,071               | 30             | 30             |
| Stark      | 234,887              | 286            | 312            |
| Summit     | 339,405              | 414            | 398            |
| Trumbull   | 132,315              | 138            | 118            |
| Tuscarawas | 68,816               | 92             | 70             |
| Union      | 20,012               | 36             | 23             |
| Van Wert   | 26,759               | 28             | 31             |
| Vinton     | 11,573               | 10             | 7              |
| Warren     | 29,894               | 39             | 44             |
| Washington | 43,537               | 63             | 58             |
| Wayne      | 50,520               | 63             | 49             |
| Williams   | 25,510               | 36             | 29             |
| Wood       | 51,796               | 62             | 50             |
| Wyandot    | 19,218               | 26             | 28             |
| Totals     | 6,907,612            | 9,534          | 9,702          |

### Public Pools Must Be Approved

Plans for public swimming pools in Ohio must be submitted to the State Department of Health for approval, Attorney General Hugh S. Jenkins ruled March 3, in Opinion No. 147. The syllabus follows: Under the provisions of Sec. 1240, G.C., the state department of health is authorized to require the plans for a public swimming pool, in so far as such plans relate to the water supply or treatment works for the purification of the water supply thereof, to be submitted to said department for approval.

### War-Time Graduate Meetings

The following War-Time Graduate Medical meetings sponsored by the American Medical Association, the American College of Physicians and the American College of Surgeons, and authorized by the Army, Navy and the U. S. Public Health Service, were held in Ohio during February and March:

Feb. 22—Fletcher General Hospital, Cambridge. "Recognition and Management of Acute Thoracic Injuries", Dr. George M. Curtis, Columbus; "Surgical Diseases of Lung and Pleura", Dr. Karl P. Klassen, Columbus.

March 21—A.A.F. Regional Station Hospital, Patterson Field, Fairfield. "The Diagnosis and Treatment of the Common Arthritides", Dr. Russell L. Haden, Cleveland.

March 22—Fletcher General Hospital, Cambridge Hospital, Cambridge. "Dermatome Grafts in Chronic Osteomyelitis", Lt. Col. Robert L. Preston, M.C., consultant in orthopedics, Fifth Service Command; "Treatment of Fractures of the Foot and Ankle", Dr. Edw. Harlan Wilson, Columbus.

March 27—Crile General Hospital, Cleveland, "Problems in the Diagnosis and Management of Coronary Artery Disease", Dr. R. W. Scott, Cleveland.

Another meeting is scheduled to be held in Cleveland, April 24, at which Dr. William E. Lower will speak on "Congenital Anomalies of the Genito-urinary Tract".

Physicians in civilian practice are cordially invited to join with their colleagues in the service at these meetings. The programs for Region 8, comprising Western Pennsylvania and Ohio, are in charge of a committee consisting of Dr. Charles A. Doan, Dean of the Ohio State University College of Medicine, Columbus, chairman; Dr. Parke G. Smith, Cincinnati; and Dr. Fred M. Douglass, Toledo.

Toledo—Recent staff elections of local hospitals include the following: Riverside Hospital—Dr. H. B. Meader, president; Dr. N. B. Muhme, vice-president; Dr. H. W. Williamson, secretary; Dr. J. P. McLachlin, treasurer and Dr. J. B. Hirsch, member of executive committee. Toledo Hospital—Dr. L. F. Smead, chief; Dr. J. L. Stifel, vice chief; Dr. C. H. Reams, secretary-treasurer; Dr. R. H. Elrod, director of surgery; Dr. Stifel, director of medicine; Maumee Valley Hospital—Dr. Nelson Morris, director of medicine; Dr. E. J. McCormick, director of surgery.

Cleveland—A special committee of the Cleveland Academy of Medicine, with Dr. William E. Hill as chairman, is advising the Garment Workers Union concerning their plan for physical examination and health education of the Union members.



# SMOOTHAGE

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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



# Michigan Medical Service Showing Continued Progress and Growth, Detroit Medical News Article Reveals

Editor's Note: Michigan's experiment in offering the people medical, surgical and obstetrical services on a voluntary prepayment basis, known as Michigan Medical Service, has been watched with great interest by the medical profession and the public ever since its birth in 1939. Michigan, under the guidance of the Michigan State Medical Society, pioneered. Its program has had its ups and downs. It has been criticized and commended.

One thing for sure which can be said is that Michigan had the nerve to pioneer and that its plan has progressed farther than any similar venture.

The Ohio State Medical Association is making progress in planning for a voluntary prepayment medical program in Ohio. The Ohio plan will differ from the Michigan plan but fundamentally it will have the same purpose. At present Ohio is behind Michigan. Maybe it can catch up. Certainly it should attempt to do so.

The Journal believes that Ohio physicians will be interested in knowing how Michigan has been getting along with its experiment. The following article published in the March 5, 1945, issue of the Detroit Medical News, official magazine of the Wayne County Medical Society, indicates that Michigan Medical Service is not doing so badly and is not quite as "delicate" as some of its critics contend:

\* \* \*

## "A DELICATE PLANT"

(From the *Detroit Medical News*)

**T**HE Michigan Plan seems definitely to be a delicate plant." A quote from Dr. Garfield of the Kaiser Industrial Medical Service Plan and reprinted in numerous medical journals throughout the country.

"Delicate—adj.: frail; easily injured; weak; fine in texture; refined; fastidious; dainty; sensitive; light in color; finely adjusted; skillful; slight." (Webster's Dictionary.)

So Michigan Medical Service is "delicate". We wouldn't argue with Dr. Garfield for he has developed a good plan of medical care for the situation he controls. However, on consulting the dictionary he may find an interpretation that makes his plan also "delicate". Instead, as Al Smith used to say, "Let's look at the record" of Michigan Medical Service and see how the term "delicate" applies.

Michigan Medical Service is about to start on its sixth year of actual operation. It started on a shoestring with less than \$20,000 to invest in setting up an organization and comparatively less in actuarial figures or ideas on how to run such an organization. Admitting that it had a stormy beginning and that it has had to cut back from its original plan for over-all care to its present surgical contract, and that it has had to battle for its existence both within the medical profession and without, let's see how healthy this "delicate" 5-year-old baby is.

### FINANCIAL RECORD GOOD

As of January 1, 1945, the Michigan Medical Service has so far paid out for services to its clientele \$9,484,285.12. During the year 1944 it paid to the physicians of Michigan for services

rendered, the sum of \$3,437,265.50 as compared with \$172,115.00 during the year 1940. Of course these are "delicate" sums during the present billion dollar era but there is no Federal money in the organization. As of present writing, Michigan Medical Service has no outstanding indebtedness except current bills and \$2,302.84 unpaid on former prorated fees (cases in which the corporation is unable to ascertain the persons to whom the amount should be paid). The corporation owns \$500,000 in government bonds and has cash on hand and in bank of \$609,828.01. In 1944, the premiums earned amounted to \$4,512,755.87 and the cost of administration of the plan amounted to 11.44% of income and about 80% of income was paid out for services rendered to the subscribers. An adequate reserve has been set up to cover unreported services and a good beginning has been made on developing a surplus fund. The Michigan State Insurance Commission auditors have just completed an audit of the Corporation and in their figures, increased the amount of funds allotted to surplus over those of the corporation's controller. Following this audit, the state insurance commissioner allowed the corporation to pay up all its moral obligations although the Medical Service was not legally bound to do this at the present time. Financially the baby is standing on its own delicate feet. A commercial business, no endowments, no gifts, no Federal funds.

### THOSE COVERED TOTAL 717,420

At the present time, Michigan Medical Service has 295,478 outstanding contracts providing surgical coverage to 717,420 persons in Michigan,



# CAROTENE

(PROVITAMIN A)

## PREPARATIONS

REG. U. S.  PAT. OFF.

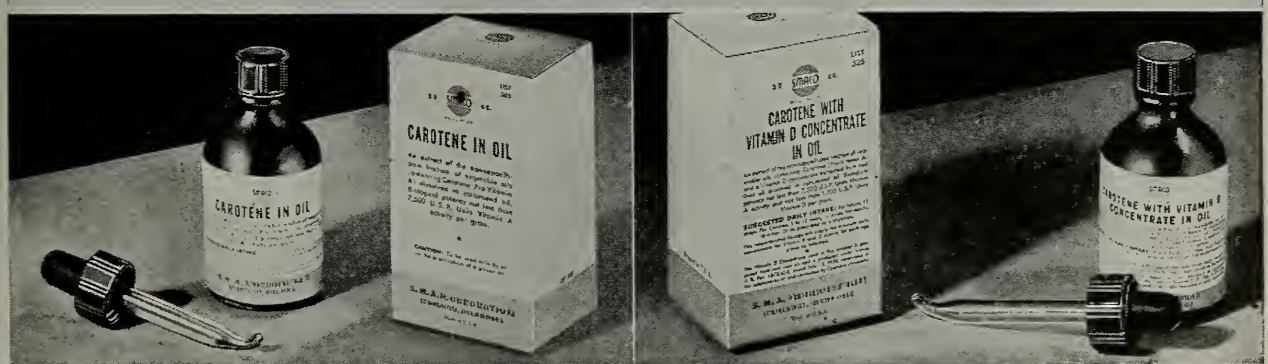
### *For the Management of Vitamin A Deficiencies*

## CAROTENE

THE NATURAL SOURCE OF VITAMIN A ACTIVITY

Carotene is especially desirable in pregnancy for it has been shown that it is carotene, mainly, and not vitamin A, which is supplied to the fetus. "Vitamin A, in contrast to carotene, either is not transmitted or is poorly transmitted from the mother to the fetus."<sup>1</sup>

CAROTENE PRESCRIPTION PRODUCTS ARE PLEASANT TO TAKE



#### CAROTENE IN OIL

Vial: 50 cc. with dropper 7,500 units of vitamin A activity per Gm.  
Dose: For infants and young children,  $\frac{1}{2}$  to 1 teaspoonful daily; supportive, 8 to 12 drops daily.  
Also available in capsule form.

#### CAROTENE

#### with Vitamin D Concentrate in Oil

Vial: 50 cc. with dropper 7,500 units of vitamin A activity; 1,000 units of vitamin D per Gm.  
Dose: For infants and young children,  $\frac{1}{2}$  to 1 teaspoonful daily; supportive, 8 to 12 drops daily.

AT PHARMACIES ONLY

<sup>1</sup>LUND C. J., and KIMBLE M. S.: Plasma Vitamin A and Carotene of the Newborn Infant, Am. J. Obst. and Gynec. 46: 207-221 (Aug.) 1943.

or better than one in eight persons in the state, are covered. Sixty thousand and three hundred new contracts were written in the past year, 67,871 separate services rendered to its subscribers were paid for and, as said before, \$3,437,265.50 was paid to Michigan physicians in 1944. In the official Michigan Insurance Report on the leading health and accident insurance companies doing business in the state, Michigan Medical Service was third in premium income and second in claims paid, Michigan Hospital Service holding first place in each classification. These contracts cover the whole family and there are no time limits on any service except maternity care (nine months). Insure today and draw benefits tomorrow. ("Delicate" Motto.) It is interesting to note that 29% of the services rendered are to the subscribers while 71% are to dependents, 19.56% are rendered to sons and 14.7% are to daughters.

The plan is on a service basis with participating physicians for the individual of under \$2,000 annual income or the family under \$2,500 income. Better than 65% of the physicians of the state are participating and a large percentage of the non-participating physicians accept the Service fees in full for these lower income groups. The fees paid are established by an advisory board composed of participating and non-participating physicians and with the exception of appendectomy (\$75) and tonsillectomy (\$25) are equal to or better than most plans. The fee schedule is elastic so that individual cases may be adjusted by these advisory boards. The contracts are written for groups but on an individual basis so that a client, changing position or group may continue his contract by paying his premium individually. The Service has reciprocity agreements with 14 other service plans throughout the country so that the client can carry on his contract if he should move to one of the localities covered by one of these plans. It is a "delicate" situation that there are not enough such plans to cover the whole country as yet.

At the present, a new medical and surgical contract is in the process of formation so as to cover all medical as well as surgical care while hospitalized and will be put in force shortly at only a very slight increase in premiums. The present surgical contract premiums are as low as any company handling similar contracts. Also, in Michigan, an attempt has been made to separate the professional services from the hospital services; Michigan Medical Service pays the X-ray and anesthetic services and negotiations are going on now to cover the pathologist services. This is really a "delicate" matter.

#### FEW ARE DISSATISFIED

A lot has been heard of the dissatisfaction on the part of the subscriber. Sixty thousand and

three hundred new contracts in a year doesn't bear that out. Judging from reports of unions (U.A.W.-C.I.O.) submitted to the International Executive Board a good percentage of union members are favorable to the organization. We quote from one report:

"This Committee's first duty to the rank and file is to inform the International Board members that we Michigan Auto Workers are now enrolled in the best Hospital and Medical Insurance to be found anywhere in these United States." . . .

. . . "Michigan Medical Service writes the most liberal contract we have ever seen and fully protects women who are two and one-half times the surgical risk men are; plus the fact that they actually pay 90% of the premium dollar back in benefits."

Michigan Medical Service and Michigan Hospital Service supports a grievance committee elected by the unions to handle any controversies between the subscribers and the corporation in the same manner the medical advisory boards handle the grievances between the physicians and the corporation. This is a "delicate" item handled in a fair and delicate manner and from the standpoint of the corporation it has worked out well. The A. F. of L. has a representative on the Board of Directors who has given invaluable service to the organization. The U.A.W.-C.I.O. had one but since he resigned, they have so far failed to nominate anyone to take his place although such a nomination has been requested. The U.A.W.-C.I.O. have been asking a 50% representation on the Board since.

The Michigan Medical and Hospital Services have been writing contracts in combination with commercial companies (life insurance and sick benefits contracts). In this manner a total insurance package can be offered the worker. Typical is the packet offered by the Chrysler Corporation. Again quote the U.A.W.-C.I.O. report.

"Seven dollars and thirty-five cents per month gives the employee \$3,000 life insurance, sick (\$21 a week benefit for 26 weeks) and death benefits plus the best hospital and surgical benefits for the whole family."

Six dollars and thirty-eight cents offers the same benefits for husband and spouse and \$4.68 covers the single employee. Most physicians would welcome such a contract for their personal use.

#### ALTERNATIVE TO U.S. PROGRAM

This same report doubts the ability of the union to write a prepayment plan of medical care of their own that can compare with the Michigan plan and they realize that building their own hospitals and clinics could care for only a small fraction of their membership. However, they do feel that a Federal Government plan is the Utopia. Quote:

"And conclusively, this committee is of the





*for* **I**nfa<sup>n</sup>ts and **C**hild<sup>r</sup>en

MILK DIFFUSIBLE *Vitamin D* PREPARATION

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

*does not float on milk*  
*does not adhere to bottle*  
*does not have a fishy taste or odor*

Drisdol in Propylene Glycol—10,000 units per Gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.



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 Pharmaceuticals of merit for the physician WINDSOR, ONT.

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 Crystalline Vitamin D<sub>2</sub>  
 from ergosterol

opinion that the most righteous and worthy service our International Board can render the rank and file members is to stop tinkering with insurance schemes and get to work on the passage of social legislation that will make the Federal Government responsible for the health of the people of this nation."

In the meanwhile, they feel that the medical profession of the State of Michigan has given them the best answer to date. And the Michigan physician knows he has a producers cooperative established through which he may be able to deal with any Federal legislation.

Michigan Medical Service is not the Utopia for medical care but it is now in a position to slowly spread its wings. More coverage will gradually come about. Reciprocity (14 plans now) with other like plans is still necessary to cover the migratory worker. As a side line the commercial insurance companies should make their contracts on an individual basis so that the worker who changes positions would not lose his sick and death benefits. Workers need to be better informed on how and for what benefits he is covered. Some method must be found to sell contracts individually as well as in groups so as to cover more of the public. The physicians' cooperation should be better. No physician has a desire to be in the insurance business but if it is necessary to help in the distribution and to lower the cost of medical care, then we must do it. For any plan to succeed, there must be cooperation between the physician, the corporation and the subscriber to the mutual benefit of each party. Medical care, its distribution and its cost are all a delicate subject.

#### TRYING TO SOLVE A PROBLEM

In conclusion, we ask the editors of our medical journals not to print cynical criticisms regarding any of the plans their fellow physicians are attempting until they have some knowledge of what they speak. All of us are striving to do our best for the medical profession and for their patients. We will all make mistakes but those making mistakes are at least trying to solve the problem and not adopting a defeatist attitude.

Yes, Michigan Medical Service is a "delicate plant" but we think it has grown a few blossoms of unusual beauty and stamina and that with a little more fertilizing it may develop into a sturdy perennial that can be pointed to with pride by the medical profession of the whole U.S.A. and by its loyal subscribers who helped cultivate it in the poor soil we had to start with. Remember it is private business, no endowments, no gifts and no Federal loans or funds.

Lorain—"Bone Carpentry", was the topic of a talk given by Dr. M. C. Kolecun at a meeting of the Kiwanis Club.

## Program To Provide More Physical Therapists Inaugurated

A critical shortage of qualified physical therapists which endangers the proper care of infantile paralysis victims has caused The National Foundation for Infantile Paralysis to appropriate \$1,267,600 for the training of these vitally needed specialists, Basil O'Connor, president, has announced. The program developed under the guidance of a special committee established in the field of physical therapy consists of three parts:

(1) \$1,107,000 for scholarships to train new physical therapists.

(2) \$82,000 for fellowships to provide additional teachers and,

(3) \$78,600 for general development of the field of physical therapy.

Preparation for entrance into approved schools of physical therapy requires graduation as a nurse, or physical educator, or two years' college training including biology and other basic sciences. Applications for scholarships should be made to The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y., or to the American Physiotherapy Association, 1790 Broadway, New York 19, N. Y.

## Sale of Eyeglasses Taxable

Following is the syllabus of an Opinion of the Ohio Supreme Court (No. 30147) February 28, 1945, in the case of Rice, Appellant, v. Evatt, Tax Commr., Appellee; relating to the retail sales tax on the sale of eyeglasses:

1. A transfer of the title to complete eyeglasses or other optical accessories to a patient for a consideration, by one practicing the limited profession of optometry, constitutes a sale within the meaning of the sales tax law (Section 5546-1 et seq., General Code) and is taxable at the bracket rate provided for in Section 5546-2, General Code.

2. One practicing optometry is liable to an assessment of three per centum of the receipts from retail sales, under authority of Section 5546-12a, General Code, where he examines and measures the eyes of his patients and furnishes to them complete eyeglasses or lenses to fit the eyes, for a consideration without fixing a separate price for such optical accessories and without paying to the state any amount of the sales tax provided for in Section 5546-2, General Code, by means of cancelling prepaid tax receipts.

Eaton—One of the speakers at the Annual Achievement Day of the Preble County home demonstration groups was Dr. Robert K. Finley, Dayton, who spoke on "Cancer Control".



DAWN OF A NEW DAY IN MEDICINE



# PENICILLIN

The ever-increasing mass production of Penicillin is bringing Medicine closer and closer to the day when this potent antibiotic will be freely available for the treatment of many diseases which in the past have defied therapeutic measures.

To make that day an early tomorrow, CHEPLIN LABORATORIES is devoting its peak production efforts.

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## Study Indicates Need for More Hospitals in Rural Ohio; Guideposts for Future Planning Are Suggested

**A**N INTERESTING and informative study entitled, "Hospitals for Rural People in Ohio" has just been completed by A. R. Mangus, Department of Rural Economics and Rural Sociology Ohio State University.

Readers of *The Journal* will recall that it has published in full or in part a number of Mr. Mangus' studies on medical and health questions as they relate to rural residents of Ohio, notably his study on "Health and Human Resources in Rural Ohio", published in the September, October, November and December, 1944, and January, 1945, issues, and his investigation of voluntary medical service plans, published in the November, 1943, issue.

In his report on the present hospital situation in Ohio, Mr. Mangus describes the nature of modern hospitals; reviews the general hospital services in Ohio; shows the different types of hospitals, location and the relationship between population and hospital beds, and states assumptions for future hospital planning in Ohio.

Believing that his observations and recommendations on planning general hospitals for rural people in Ohio will be of interest and value to the medical profession, *The Journal* presents as follows, the chapter of Mr. Mangus' report dealing with this subject:

"As this report has shown hospital services are not available to rural people on the same basis as they are to urban people in the larger cities. The rural areas have fewer general hospital beds per 1,000 population, and many rural families live in localities that are rather far removed from any hospital. Many rural areas that do have some hospital service near at hand do not have it in the same quality as do residents of the large cities. Some rural hospitals do not meet even the comparatively simple requirements for registration by the American Medical Association, and only about one in each six small hospitals with less than 50 beds are able to meet the minimum requirements for approval by the American College of Surgeons.

"If the best of modern medical care and health services is to be made available to rural people, it seems clear that hospitals must play a very important part in the achievement of that purpose. Realizing that fact, rural people are considering ways and means by which they can gain easier access to the best hospital services. In several rural counties plans are already under way for hospital building programs in the postwar period. There is need for the most careful planning for future extension of hospital facilities if they are to meet rural needs in the postwar world. Such planning is required not

only at local levels but also at district, state, regional and national levels as well.

"It is not the purpose of this report to consider the matter of detailed planning of hospitals for rural people. Certain general assumptions for planning may, however, be stated. These assumptions are being made rather generally among those authorities who are giving the most careful thought to rural hospital, medical, and health needs. They may, therefore, be taken as guideposts for future hospital planning.

**"1. Hospitals should be developed to serve as local medical and health centers.**

"An older assumption was that where a large urban hospital or medical center exists no other hospital should be built within a radius of 50 miles of that center, particularly if good roads and good ambulance services are available for transporting patients. That assumption is now pretty thoroughly discredited. It was based on the thought that the hospital was to serve primarily as a workshop for medical doctors and as a hotel for sick people in need of bed services.

"The newer conception of the hospital is that of a community medical and health center. Such a center serves to link and coordinate local medical and health services, and it serves to improve the quality of medical care in the local area. A well-equipped and well-organized rural hospital provides laboratory and diagnostic facilities to be used by local physicians in the diagnosis and treatment of all the people of the locality as well as the relatively few who require hospitalization.

"Such a local hospital should serve to attract young and well-trained physicians to the more rural areas, and should encourage good doctors to remain in country practice. It should, if properly operated, give rural people a better understanding of modern medical care and its possibilities for human welfare. It would encourage greater utilization of hospital beds by rural people who need hospitalization but who may refuse to go to a distant hospital where they would be out of touch with their family, their friends, and with their family doctor.

**"2. Rural hospitals should be developed as integral links in a regional system of hospitals.**

"It is doubtful whether local hospitals outside the larger centers of population can best serve the needs of rural people so long as they remain isolated from other health services and from other hospitals. One of the most significant proposals now under consideration by hospital planners is that the present unorganized aggregation of general hospitals be organized on regional bases. Under such a system, the smaller rural hospitals or medical centers would have very



definite service relations with larger and more adequately staffed hospitals in the big urban centers. The specialists' service available at the larger medical centers would be extended out to the outlying rural institutions. Specialists in pathology, in radiology and in the many medical specialties would be made available to visit the outlying hospitals to see certain patients and to consult with local physicians regarding their most difficult cases.

"The rural hospitals or medical centers, in turn might have close service relations with smaller public health centers in sparsely settled rural areas which could not afford a hospital of their own. Such a regional system of medical centers would include the following types of centers according to size and completeness of services.

**"a. Large Base Hospitals.** Such a hospital preferably would be one which serves as a teaching unit of a medical school. It would be a center that provides all types of hospital services including complete diagnostic, therapeutic, teaching, and research facilities.

"In Ohio such hospitals are found in the three cities of Cleveland, Columbus, and Cincinnati, each of which is the site of a university medical school.

**"b. District Hospitals.** Such hospitals would probably be smaller than the base hospitals but would provide all types of hospital services including complete diagnostic facilities and would provide for the instruction of interns, technicians, nurses, and hospital dietitians. In Ohio such hospitals would be found in most of the centers with 40,000 or more population.

**"c. Rural Hospitals.** Rural hospitals would be those located in the smaller cities and therefore closely accessible to rural people. They would provide laboratory and X-ray services which might be supervised by pathologists and radiologists from the larger centers. These hospitals or rural medical centers would also provide at least minor and emergency surgery, obstetrical and medical services. The more difficult cases would, however, be sent to the larger and more adequately equipped and staffed medical center at the district or regional level.

"The rural hospital might well serve as the community medical and health center by providing office space for local doctors and dentists and by housing the local public health department.

**"d. Public Health Centers.** In the more sparsely settled rural areas where a rural hospital would not be feasible the public health unit might be expanded and augmented to provide a public health center. Such a center would provide a few beds for maternity service and emergency surgery.

It would also provide laboratory and limited X-ray service supervised by visiting pathologists and radiologists as in the rural hospital. Local doctors and dentists as well as the health department personnel would be housed in this small facility.

**"3. The costs of hospital services should be financed through a prepayment plan.**

"The principle of prepayment is now generally accepted in this country, and is now well known in practice as a result of the Blue Cross plans sponsored by the American Hospital Association. Such plans should be adopted and expanded to include rural people as well as employed urban groups. Prepayment plans should also be expanded to cover the costs of medical, surgical and obstetrical as well as hospital services.

**"4. Health Education.** In order to get increased utilization of hospital services rural people need to be better informed as to the nature of modern medical care and health services. In particular there is need to provide more information to rural people regarding the functions of the modern hospital and its role in the distribution of medical care and health services.

**"5. Hospital planning for rural people should be based on research.**

"This report is based on research which only provides an approach to that needed as a basis for hospital planning in line with the principles indicated above. Such research is needed to determine the logical boundaries of regions, districts, and local areas for hospital service within Ohio and where new hospitals should be constructed or where existing facilities should be expanded, maintained, or abandoned. For each hospital service area or sub-area information should be compiled regarding the population and geographic factors, economic status, health status, medical and related personnel, medical care practices, utilization of existing facilities, and methods of payment for hospital care.

"The American Hospital Association through its Committee on Postwar Planning has already set up an independent, non-political, public service group known as the Commission on Hospital Care. That Commission is now engaged in a study of present facilities, practices, policies, and programs of hospitals of all types in Michigan and in one or two other states. The Commission is expected to suggest general plans for the further development and coordination of hospital services.

"A similar agency should be established for Ohio. The objectives would be:

**"a.** To survey in detail through field contacts, the existing hospital and health center facilities in the State.

**"b.** To make an authoritative appraisal of hospital and health center needs in Ohio.

**"c.** To draft an over-all state hospital plan."



# Names on Military Roster Total 3,115; Those Receiving Promotions Listed; Breakdown by Counties

FOUR NAMES were added to the Military Roster of the Ohio State Medical Association during the past month. Names on the roster as of March 20 totaled 3,115, divided as follows: Army, 2,596; Navy, 446; miscellaneous governmental services, 73. The star in front of names listed below indicates the physician has been in service for some time but that this information has just been received by *The Journal*. Names added to the roster, those receiving promotions, and a tabulation by counties, follows:

## NAMES ADDED TO MILITARY ROSTER

| Name                | City            | Rank               |
|---------------------|-----------------|--------------------|
| Bakody, John T.     | Columbus.....   | Lt., U.S.N.        |
| *Barson, Lloyd J.   | Van Wert.....   | 1st Lt., U.S.A.    |
| Haskin, Grace       | Cleveland.....  | Lt. Comdr., U.S.N. |
| *Slemmer, Robert E. | Cincinnati..... | Lt., U.S.N.        |

## WIN PROMOTIONS

| Name                 | City                  | Rank               |
|----------------------|-----------------------|--------------------|
| Ayres, P. R.         | Columbus.....         | Lt., U.S.N.        |
| Barnard, Wm. H.      | Toledo.....           | Lt. Col., U.S.A.   |
| Barr, Harry R.       | Cleveland.....        | Lt. Comdr., U.S.N. |
| Beeson, Harold G.    | Wooster.....          | Major, U.S.A.      |
| Blackburn, John H.   | Kalida.....           | Capt., U.S.A.      |
| Blondis, Robert R.   | Shaker Heights.....   | Capt., U.S.A.      |
| Brickman, Edward M.  | Cleveland.....        | Major, U.S.A.      |
| Campbell, Geo. W.    | Columbus.....         | Capt., U.S.A.      |
| Castle, Charles A.   | Cincinnati.....       | Lt. Comdr., U.S.N. |
| Chrenka, Paul        | Cleveland.....        | Capt., U.S.A.      |
| Crone, John T., Jr.  | Milford.....          | Major, U.S.A.      |
| Decker, Martin       | Middletown.....       | Capt., U.S.A.      |
| Duckwall, Henry M.   | Dayton.....           | Capt., U.S.A.      |
| Edwards, Thomas L.   | Van Wert.....         | Major, U.S.A.      |
| Egeberg, Roger O.    | Cleveland.....        | Col., U.S.A.       |
| Feldman, Edward G.   | Columbus.....         | Capt., U.S.A.      |
| Franz, Lyle C.       | Cincinnati.....       | Capt., U.S.A.      |
| Goodman, Lawrence H. | Findlay.....          | Lt. Col., U.S.A.   |
| Hardgrove, Geo. L.   | Doylestown.....       | Lt. Col., U.S.A.   |
| Heery, Ralph         | Cincinnati.....       | Capt., U.S.A.      |
| Jacka, Edwin R.      | Bryan.....            | Major, U.S.A.      |
| Kelker, John R.      | Fairview Village..... | Major, U.S.A.      |
| Lacock, Wilford C.   | Beaverdam.....        | Major, U.S.A.      |
| Leibschner, Wm. R.   | Deshler.....          | Capt., U.S.A.      |
| Martz, Raymond W.    | Hamilton.....         | Capt., U.S.A.      |
| Miller, James M.     | Marion.....           | Capt., U.S.A.      |
| Myers, Ben Vernon    | Elyria.....           | Lt. Col., U.S.A.   |
| Neiman, Roland E.    | Cincinnati.....       | Major, U.S.A.      |
| Pater, Joseph L.     | Hamilton.....         | Capt., U.S.A.      |
| Paternite, Carl J.   | Toledo.....           | Capt., U.S.A.      |
| Paul, Raphael N.     | Dayton.....           | Capt., U.S.A.      |
| Schneider, Louis W.  | Hamilton.....         | Major, U.S.A.      |
| Sloan, Richard H.    | Marietta.....         | Capt., U.S.A.      |
| Stelzner, Glenn W.   | Newcomerstown.....    | Capt., U.S.A.      |
| Strait, John M.      | Columbus.....         | Capt., U.S.A.      |
| Ward, Geo. J.        | Cleveland.....        | Capt., U.S.A.      |
| Wells, Wm. D.        | Milford.....          | Capt., U.S.A.      |
| Wirtz, Myron A.      | Cleveland.....        | Lt. Col., U.S.A.   |

## TABULATION BY COUNTIES

|                 |    |                  |     |                |     |
|-----------------|----|------------------|-----|----------------|-----|
| Adams .....     | 2  | Clinton .....    | 8   | Gallia .....   | 5   |
| Allen .....     | 39 | Columbiana ..... | 12  | Geauga .....   | 4   |
| Ashland .....   | 12 | Coshocton .....  | 4   | Greene .....   | 4   |
| Ashtabula ..... | 18 | Crawford .....   | 9   | Guernsey ..... | 7   |
| Athens .....    | 11 | Cuyahoga .....   | 787 | Hamilton ..... | 510 |
| Auglaize .....  | 6  | Darke .....      | 6   | Hancock .....  | 12  |
| Belmont .....   | 14 | Defiance .....   | 4   | Hardin .....   | 7   |
| Brown .....     | 1  | Delaware .....   | 7   | Harrison ..... | 4   |
| Butler .....    | 30 | Erie .....       | 11  | Henry .....    | 3   |
| Carroll .....   | 2  | Fairfield .....  | 9   | Highland ..... | 7   |
| Champaign ..... | 9  | Fayette .....    | 2   | Hocking .....  | 4   |
| Clark .....     | 37 | Franklin .....   | 255 | Holmes .....   | 2   |
| Clermont .....  | 9  | Fulton .....     | 6   | Huron .....    | 17  |

|                 |     |                  |     |                  |      |
|-----------------|-----|------------------|-----|------------------|------|
| Jackson .....   | 1   | Monroe .....     | 0   | Scioto .....     | 20   |
| Jefferson ..... | 28  | Montgomery ..... | 164 | Seneca .....     | 11   |
| Knox .....      | 10  | Morgan .....     | 3   | Shelby .....     | 7    |
| Lake .....      | 19  | Muskingum .....  | 9   | Stark .....      | 101  |
| Lawrence .....  | 7   | Noble .....      | 1   | Summit .....     | 162  |
| Licking .....   | 17  | Ottawa .....     | 9   | Trumbull .....   | 27   |
| Logan .....     | 8   | Paulding .....   | 2   | Tuscarawas ..... | 20   |
| Lorain .....    | 39  | Perry .....      | 4   | Union .....      | 2    |
| Lucas .....     | 182 | Pickaway .....   | 5   | Van Wert .....   | 11   |
| Madison .....   | 6   | Pike .....       | 2   | Vinton .....     | 2    |
| Mahoning .....  | 141 | Portage .....    | 3   | Warren .....     | 4    |
| Marion .....    | 16  | Preble .....     | 7   | Washington ..... | 8    |
| Medina .....    | 13  | Putnam .....     | 6   | Wayne .....      | 13   |
| Meigs .....     | 3   | Richland .....   | 38  | Williams .....   | 8    |
| Mercer .....    | 6   | Ross .....       | 22  | Wood .....       | 19   |
| Miami .....     | 15  | Sandusky .....   | 12  | Wyandot .....    | 3    |
| Total .....     |     |                  |     |                  | 3115 |

## Army General Hospitals in Ohio Being Enlarged

An expansion program involving an expenditure of approximately \$750,000 is under way at Ohio's two Army General Hospitals, Crile General Hospital, Parma Heights, near Cleveland, and Fletcher General Hospital, Cambridge.

Thirteen new buildings are being constructed at Crile General Hospital to house enlisted personnel and members of the Women's Army Corps. The estimated cost is \$250,000. Upon completion of the new buildings, nine barracks in the hospital will be available for conversion into seven wards. The rearrangement of present facilities will make available 371 more beds, increasing the authorized capacity from 1,867 beds to 2,248.

Fletcher General Hospital will be expanded from 1,500 beds to 2,020 beds with the construction of 13 additional buildings, at an estimated cost of \$459,000. The expansion will include equipping of 11 barracks now used for WACs and medical personnel for use as hospital wards and construction of one brick building and 12 theater-of-operations type wooden barracks to house the staff.

Cincinnati—Dr. Marion Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, spoke on "Modern Concept of Nutritional Diseases", and Dr. Cecil Striker, secretary of the American Diabetes Association, discussed "Recent Advances in Clinical and Laboratory Investigation of Diabetes", at a War Time Graduate Medical Meeting, Jan. 18, at Fletcher General Hospital, Cambridge.

Columbus—Dr. Harold T. Sargis, Ohio State University College of Medicine graduate in 1941 is chief resident in obstetrics and gynecology at Cook County Hospital, Chicago, and Dr. James Hayhurst, O.S.U. '43, is junior resident in urology there.

Galion—Dr. H. H. Hartman, dean of Crawford County physicians, has been in active practice for 55 years.



**"I'M SO GLAD DOCTOR  
PRESCRIBED BAKER'S  
MODIFIED MILK"**



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## A Highly Nutritious Food for Infants...

from birth throughout the bottle feeding period

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- *A food that is well tolerated by both premature and full-term infants . . .*
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**T**HESE are reasons why Baker's Modified Milk is so steadily gaining wide prescription.

Applicable to practically all infant feeding cases during the entire bottle-feeding period, Baker's is a time-saver for today's busy physician. And mothers like to feed Baker's because it is convenient and economical to use. With Baker's there's little chance for error, for there's

only one thing to do—dilute to prescribed strength with water, previously boiled.

The mother enjoys a well-nourished and happy baby, because Baker's is well-supplied with the nutritive elements for normal growth and fortified with seven dietary essentials, including liberal protein content (60% more than human milk). Write for samples and complete information.

Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B<sub>1</sub> and D. Not less than 400 units of vitamin D per quart.



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# In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

## NEED FOR IMPROVING VETERANS' HOSPITAL SERVICES STUDIED

Revamping of the Veterans' Administration facilities with a view toward improving the quality of medical services of such facilities and expansion of its personnel, equipment, etc., may result from studies which are being undertaken by the Subcommittee on Wartime Health and Education of the United States Senate Committee on Education and Labor, with the help of authorities in medical specialties, veterans' organizations and professional groups.

This survey should have the support of the medical profession as the profession knows the present program of the Veterans' Administration is not capable of meeting the heavy responsibilities with which that agency will be faced in the future. As the subcommittee referred to above has stated in its interim report on "Health Needs of Veterans", recently released:

"Criticisms of the quality of service given by the Veterans' Administration have been made to the subcommittee by organizations and individuals who speak authoritatively. It has been stated that the medical care of veterans does not measure up to the best standards."

Obviously, the cooperation of physicians in private practice in the nation's efforts to provide quality medical care for handicapped veterans will be imperative. There will have to be a close working relationship between private physicians and the Veterans' Administration as many handicapped veterans will desire the advice and services of their own doctors. However, civilian physicians will not be expected, and will not be able, to handle many thousands of cases which will arise, probably for many years after the war. Unless the quality of services in the Veterans' Administration facilities is elevated to a par with the quality of services in civilian practice, the individual veteran will be dissatisfied and an unbearable burden will be placed on civilian physicians.

As to policy with respect to the future setup of the Veterans' Administration, the subcommittee in its report makes this pertinent, and basically sound, statement:

"The subcommittee believes that the major concentration of the Veterans' Administration should be on the care of those disabled in the service. The provision of full care for all who have any service-connected disability would greatly expand the volume of out-patient care re-

### Editor's Note:

Physicians who have not done so should read the article published in the January, 1945, issue of *The Journal*, "Conditions Under Which Private Physician and Civilian Hospital Will Be Paid for Care of Disabled Veteran", which contained many important facts relative to the relationship between the civilian physician and the Veterans' Administration.

There are three Veterans' Administration facilities in Ohio with which Ohio doctors will have dealings as more handicapped veterans return to civilian life, namely:

Veterans' Administration Facility,  
Brecksville;

Veterans' Administration Facility,  
Chillicothe;

Veterans' Administration Facility,  
Dayton.

quired of the Administration. Medical care of veterans not having service-connected disabilities should be considered mainly the responsibility of the communities where these veterans live. It would be well for localities to begin now to plan their health programs on this basis."

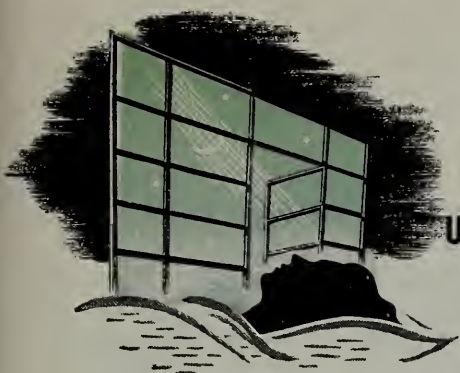
Space will not permit the publication of the subcommittee report but the views of the subcommittee and its plans are analyzed briefly in the following summary of its recommendations:

"1. Full medical care by the Veterans' Administration should be made the right of every veteran who has sustained a service-connected disability, whatever the origin of the condition for which he needs treatment. Care should include hospitalization and out-patient treatment for all of his ailments.

"2. In order to assure availability of adequate medical care for the great body of veterans—13,000,000, more or less—who will not have service-connected disabilities, measures should be initiated as promptly as feasible to meet the medical needs of the whole population in accordance with recommendations set forth in the subcommittee's Interim Report No. 3 on the Nation's health.

"3. Expansion of Veterans' Administration hospital facilities should be carried as far as may be required to assure full care of veterans with service-connected disabilities. It is also desirable that the Veterans' Administration should continue to provide hospitalization, when beds are available, for care of any veteran unable to pay for such service or to obtain it in his own community.





## UNOBSTRUCTED BREATHING ...UNDISTURBED SLEEP

- Decongestion of the nasal airway is promptly achieved by topical application of Neo-Synephrine, without causing wakefulness. Neo-Synephrine exerts prolonged local vasoconstriction and is virtually free from undesirable systemic effects such as elevation of blood pressure, increase of heart rate, and central nervous system stimulation.

# Neo-Synephrine

HYDROCHLORIDE

LAEVO- $\alpha$ -HYDROXY- $\beta$ -METHYLAMINO-3-HYDROXY-ETHYLBENZENE HYDROCHLORIDE

FOR NASAL DECONGESTION



SUPPLIED in 1/4% and 1% solution, bottles of 1 fl. oz., also 1/2% jelly in collapsible tube with applicator.



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### FACTS ABOUT NEO-SYNEPHRINE

**PROMPT**, prolonged nasal decongestion through local vasoconstriction following topical application.

**EQUALLY EFFECTIVE** upon repeated use.

**WELL TOLERATED** locally, the solutions are isotonic and virtually non-

irritating to nasal mucosa.

**CILIARY ACTION** is not appreciably impeded.

**RELATIVE FREEDOM** from systemic effects widens the range of usefulness for Neo-Synephrine—manifestations of central nervous system stimula-

tion are rarely observed.

**INDICATED** for symptomatic relief in the common cold, sinusitis, nasal manifestations of allergy, and similar conditions.

**ADMINISTRATION** may be by dropper, spray, or tampon.

FURTHER FACTS FOR YOUR REFERENCE FILE WILL BE GLADLY SENT ON REQUEST

TRADE MARK NEO-SYNEPHRINE—REG. U. S. PAT. OFF.

It would be medically and economically unsound, however, to set up medical facilities for all other veterans separately from the provisions which must be made for the whole population.

"4. Federal, State, and local governments, and public and voluntary agencies, should cooperate to develop a network of mental hygiene clinics for the maintenance of mental health among veterans and the whole population.

"5. The whole program of educational, employment, and monetary benefits for veterans should be reexamined in the light of accumulated experience in order promptly to bridge gaps and remove inequalities which interfere with the health and welfare of veterans. Among obvious needs are extension of social security credits under the Federal Old-Age and Survivors' Insurance Act, dependency allowances for families of the disabled, and inclusion of merchant seamen among those eligible for educational and unemployment benefits.

"6. In order that every possible step may be taken to safeguard the health of disabled veterans, the subcommittee proposes to examine and appraise both the quality of the medical services given in Veterans' Administration facilities and the ability of the Administration to discharge the heavy duties which will be placed upon it. Special attention will be given to neuropsychiatric services. The investigation will be conducted with the help of recognized authorities in various medical specialties, of veterans' organizations, and of professional groups."

#### GOUGING THE PUBLIC WON'T BE TOLERATED

Physicians who are realistic enough to realize that a lot of the agitation for governmental medicine stems from experiences which certain individuals have encountered when dealing with inconsiderate physicians or physicians indulging in sharp practices will concur in the sentiments expressed in the following editorial published in the March issue of *The Toledo Academy of Medicine Bulletin*:

"My attention has been called to a 'Black Market' on medical fees by a certain few of our members. Some five or six men that I have heard about are charging two or three times the usual fee for night calls. People have been complaining and it is this sort of thing by the few that gives the whole of medicine a black-eye.

"Now is not the time to take advantage of the people. It is not their fault the doctors are busy, and charging double just adds insult to injury.

"Also it is this sort of thing that adds to the advocates of State Medicine. Now is the time for all medical men to do their best to satisfy the public. If the layman needs medical care, he should have it, and at no fantastic fee.

"We realize that 90 per cent of the night calls are unnecessary and the patient could easily wait until morning, or have called earlier in the day. Some have been sick two or three days before calling a doctor at 3:00 A.M. But that is no excuse. Either make the call at a reasonable fee or don't go at all. And if you don't make the call at all, you are betraying the boys who are sloshing around the 'Hell' of the fighting front. So do your part—and be glad you are here to do it."

The medical profession, both on the fighting

and home fronts, has made a glorious record so far during the war.

Wouldn't it be a shame to have that record smeared by questionable tactics on the part of a few?

#### DOES LEWIS PLAN TO OUTDEAL THE NEW DEALERS?

Outcome of the demand of John L. Lewis of the United Mine Workers for a royalty of 10 cents on each ton of coal mined with which to create a fund for a medical and rehabilitation program for members of that union will be watched with interest by a flock of people, including the medical profession.

First of all, the public at large (which will foot the bill) will wonder, no doubt, whether Lewis will be able to get away with what Petrillo did for his musicians' union. Other unions will watch and wait, laying plans in the meantime to jump on the bandwagon if Lewis gets away with his proposal. New Dealers don't like the idea at all because Lewis' plan steals their thunder—they want to provide medical benefits and rehabilitation for everybody, not just coal miners. The medical profession can begin to wonder just what kind of a deal they will get if John L. wins.

To sum it up: Just about everybody has a stake some place in the outcome of this "Little Townsend Plan" which Lewis has concocted.

It's a tough world brother, for if it isn't one thing, it's another!

No one can object to programs designed to provide miners with good medical and health services. But, the question as to whether such programs, especially on a service basis, shall be inaugurated and administered by a union or government or the medical profession itself is something else.

#### EVERY BIRTH SHOULD BE REPORTED ACCURATELY AND PROMPTLY

Child Health Day, which is observed annually on May 1, will be known this year as "Birth Registration Day". It is the hope of health officials that this designation will help focus attention of the entire public on the many important reasons for registration of every birth in the nation.

Obviously, the members of the medical profession are key men in the program to bring about complete birth registration. Each physician should feel obligated, legally and morally, to see that an accurate birth certificate is filed with the proper official for each child which he delivers.

Great progress has been made in the registration of births. Yet, birth registration in the country is far from complete. For example, even





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good to me, mister?"..**

—A typical compliment to "Biolac Babies"—and, at the same time, a reflection of the physician's good judgment.

The soft-curd characteristics of Biolac assure ease of digestion. Adjusted milk fat content facilitates digestion and assimilation, with greater freedom from fat upsets; ample lactose assures soft, natural stool formation; and a high protein level contributes to optimal growth and health.

Since Biolac supplies adequate potencies of Vitamins A, B<sub>1</sub>, B<sub>2</sub>, and D, as well as iron, the need for time-consuming calculations of extra formula ingredients is eliminated. Indeed, Biolac (supplemented with vitamin C) provides *completely* for the nutritional requirements of the infant partially or entirely deprived of human milk.

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oz. Biolac to 1½ fl. oz.  
water per pound of  
body weight.*



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**"BABY TALK" FOR A GOOD SQUARE MEAL**

*Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B<sub>1</sub>, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized. Vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.*



in Ohio with its excellent law and system relating to birth registration, the registration of estimated births is only 95.2 per cent complete. Ohio is better than the average for the nation which is 92.5 but there is plenty of room for improvement even in this state.

The war emergency has demonstrated the value of complete and accurate registration of all births. Also, it has produced conditions which have retarded the goal of 100 per cent registration. Physicians and nurses are greatly overburdened in meeting wartime needs. Routine paper work is easily overlooked. There is a great floating population making it difficult for registrars to maintain accurate records.

For these reasons, we urge Ohio physicians to give this important duty more than customary attention. Let's put Ohio at the top of the column in the percentage of births reported.

Why is birth registration so important? Each physician knows many of the answers to this question but for the purpose of refreshing his memory, a properly recorded birth certificate is vital to child or adult for the following reasons:

- To prove age, citizenship and family relationship;
- For entrance to school;
- For first work permit;
- For automobile license;
- For right to vote;
- For right to marry;
- For right to enter military service;
- For settlement of pensions;
- For Social Security benefits;
- For inheritance of property;
- For settlement of insurance;
- For establishing identity;
- For passports;
- For ration books;
- To trace ancestry.

Starting May 1, the Division of Vital Statistics, Ohio Department of Health, will issue a "Notification of Birth Registration" to parents. In this way all parents will have a way of determining whether or not a birth certificate has been filed by the attending physician or other person.

The Department states that there are a large number of adults in Ohio for whom birth certificates are not on file. This can be remedied by all persons born after 1908 by having the attending physician, if available, certify to the birth now. Those born prior to 1908 can have their birth recorded by using the Probate Court procedure provided in Section 1261-57 of the General Code of Ohio.

This reminder, we hope, will encourage physicians in all parts of Ohio to give their prompt and sincere cooperation to the efforts being made by the Ohio Department of Health, assisted by local registrars, to make birth registration in this state complete and accurate. This is not

asking too much when one fully realizes that a birth certificate is a mighty important document to every man, woman and child.

### SOUND POLICY ON MASS CHEST SURVEYS

What appears to us to be a sensible and feasible policy pertaining to mass chest surveys has been adopted by the Board of Chancellors of the American College of Radiology.

Says the radiology board:

"The American College of Radiology approves the principle of mass chest surveys for the detection of pulmonary tuberculosis for public health purposes.

"The films should be examined by physicians who are trained and competent to interpret radiographs of the chest.

"Cases showing abnormalities should be immediately referred for further study and care to local physicians, or, when this is impractical, to other available agencies.

"In case-finding surveys as a public health measure by eleemosynary agencies, the fee for roentgen interpretation of survey films should be a sum approximately equal to fifteen dollars per hour, said fee to be a matter of agreement among radiologists in the area concerned."

Mass chest surveys play an important part in present-day public health programs and should receive the endorsement and support of the medical profession providing they are carried on along the sound lines suggested above. Only those trained for this work should be utilized and, of course, a skilled physician is the only person who should be permitted to make the interpretations. Those sponsoring surveys would benefit by securing the counsel of trained physicians in communities where such surveys are contemplated, as the work should be in conformity with accepted standards. Programs conducted in this manner will produce wholesome results.

### HOW CAN ANYONE BE SURE ABOUT WASHINGTON?

Physicians, and others, are asking: "What's the situation at Washington on the question of government medicine?"

About all we know is what we read in the papers (which probably is about all most of the so-called experts know). The picture appears to be at present about like this:

The Wagner-Murray-Dingell Bill (S.1161) expired with the last Congress on December 31, 1944.

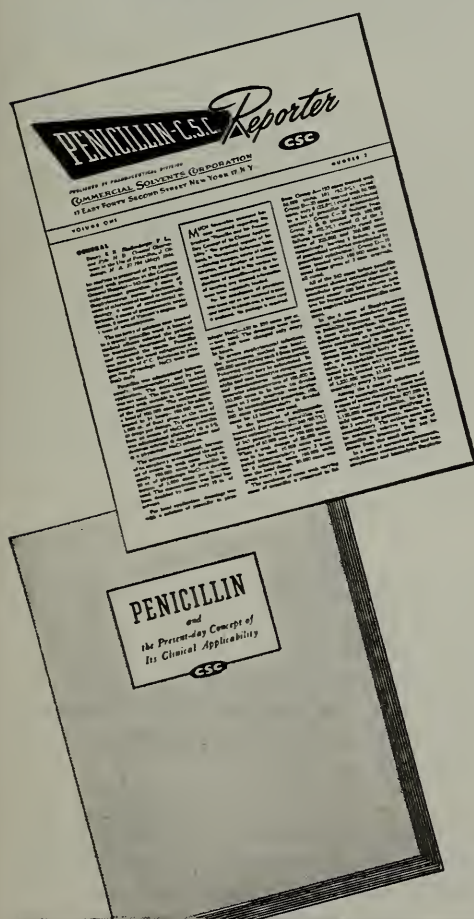
However, Mr. Dingell introduced an identical bill, H.R. 395, on the first day of the present Congress which convened in January. No hearings have been held or scheduled as yet.

The Social Security Board in its annual report to the President, advocated the establish-



# In the Management of Subacute Bacterial Endocarditis

Physicians are invited to send for this comprehensive brochure. • The Penicillin-C.S.C. Reporter, presenting abstracts of the world literature, is periodically mailed to all physicians. Notify us, if it has not been received.



**B**ARELY a year ago the reports regarding the use of penicillin in subacute bacterial endocarditis were hardly optimistic. Outstanding clinicians doubted if more than temporary sterilization of the blood stream could be expected. When the wider availability of penicillin permitted more intensive and prolonged therapy, endocarditis in many instances yielded. As recent publications show,\* this serious infection, heretofore practically hopeless, no longer need be considered so.

Since very large amounts of penicillin over long periods are required in the treatment of bacterial endocarditis, the purity of the drug administered (number of Oxford Units per milligram of substance) appears of importance. The high degree of purity accomplished in Penicillin-C.S.C. merits the physician's preference for Penicillin-C.S.C. in the management of bacterial endocarditis as well as in other indications.

\*Collins, B. C.: Subacute Bacterial Endocarditis Treated with Penicillin, J.A.M.A. 126:233 (Sept. 23) 1944.

MacNeal, W. J.; Blevins, A., and Poindexter, C. A.: Clinical Arrest of Endocarditis Lenta by Penicillin, Am. Heart J. 28:669 (Nov.) 1944.

Zimmerman, S. L., and Barnett, R. N.: Case of Probable Meningococcus Endocarditis Apparently Cured with Penicillin, South. M. J. 37:694 (Dec.) 1944.

Herrell, W. E., and Kennedy, R. L. J.: Penicillin: Its Use in Pediatrics, J. Pediat. 25:505 (Dec.) 1944.

Dawson, M. H., and Hunter, T. H.: The Treatment of Subacute Bacterial Endocarditis with Peni-

cillin, J.A.M.A. 127:129 (Jan. 20) 1945.

Nahum, L. H., and Doff, S. D.: Recent Advances in the Treatment of Heart Disease, Connecticut M. J. 9:3 (Jan.) 1945.

Poindexter, C. A.: The Use of Penicillin in the Treatment of Subacute Bacterial Endocarditis, reproduced by permission of the American Heart Association in J. Arkansas M. Soc. 41:165 (Jan.) 1945.

White, P. D.; Mathews, M. W., and Evans, E.: Notes on the Treatment of Subacute Bacterial Endocarditis Encountered in 88 Cases at the Massachusetts General Hospital During the Six Year Period 1939 to 1944 (Inclusive), Ann. Int. Med. 22:61 (Jan.) 1945.



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# PENICILLIN-C.S.C.

ment of a system of compulsory sickness insurance under the Social Security Program.

It is rumored Senator Wagner is working on a revised draft of his old bill and may introduce it soon.

It is reported the President may send a special message to Congress in the near future asking for legislation patterned after the Social Security Board's recommendation or after the Wagner Bill, in modified form.

Senator Pepper may introduce a bill soon translating into proposed legislation conclusions formed by his special sub-committee on wartime health and education which has been holding hearings since last July.

Senator Vandenberg has introduced a resolution calling for a complete study of the Social Security System. If his resolution is adopted, it is likely no Social Security legislation will be considered until that study has been completed, probably in the Fall of 1945.

As Joe Cook, of three-a-day fame, used to say: "That's all we know about the three Hawaiians".

#### SPEAKING OF "PLANNED ECONOMY" — — —

Speaking of a "planned economy" for the good old U.S.A. after the war, did you happen to read the United Press article released on February 26 about a "revolutionary food stamp program, designed to place three square meals a day within the reach of the undernourished"?

You may not be surprised to learn that the cockeyed idea originated in the Department of Agriculture and that, of course, it is masquerading under the cloak of public health and raising nutritional levels. It would only cost \$750,000,000 annually but that won't worry most of the folks at Washington.

According to the U.P. here is the way the proposed plan would work:

"Once or twice a year, the Government would determine the cost of a basic nutritional diet. In 1942, this amounted to about \$170. This amount would be designated as the 'food allotment' for one person.

"Food coupons equal to the family's total food allotment would be sold to subscribers at a price equal to 40 per cent of the family income. The coupons would be used to buy the family groceries at any public store. Stamps could be bought on the installment plan.

"If the plan were operating in 1942, a family of three with an income of \$1,000 would have been entitled to buy food coupons worth \$510 at an actual cost of \$400.

"The program is aimed primarily, but not exclusively, at families in the low-income group. Unlike the depression plan, available only to relief families or pensioners, no one would be barred.

"With at least two-thirds of the stamps a family could buy whatever food it chose. The rest, however, might be used only for foods on

a restricted list. These would include surplus food items and, possibly, food believed necessary to round out nutritional requirements.

"With an estimated 10,000,000 city subscribers, the program would cost the Government about \$750,000,000 in a relatively prosperous year such as 1942. If extended to rural families, it would rise to about \$1,000,000,000. In depression years, it would be higher."

One for the books, isn't it? Looks as if we're going to have to devise some way to out-plan the planners or give the country back to the Indians.

#### BETTER CONSERVE USE OF RADIOGRAPHIC FILM

Physicians operating X-ray machines will be interested in the following warning issued by the American College of Radiology:

"For the next three to six months you should prepare to effect every possible economy in the use of film."

Pointing out that although there will be a slight increase in quotas for medical radiographic film for civilian use for the April-May-June quarter, the radiology organization in its news letter states that "there is some doubt that manufacturers can increase production, due to manpower shortages" and that "results of increased production would not be felt by radiologists for some months".

Data cited show that essential requirements for X-ray film for all purposes during the present quarter of this year total 36 million square feet, against a maximum production capacity of 28½ million. Military demands are increasing, taking nearly one-half of total production.

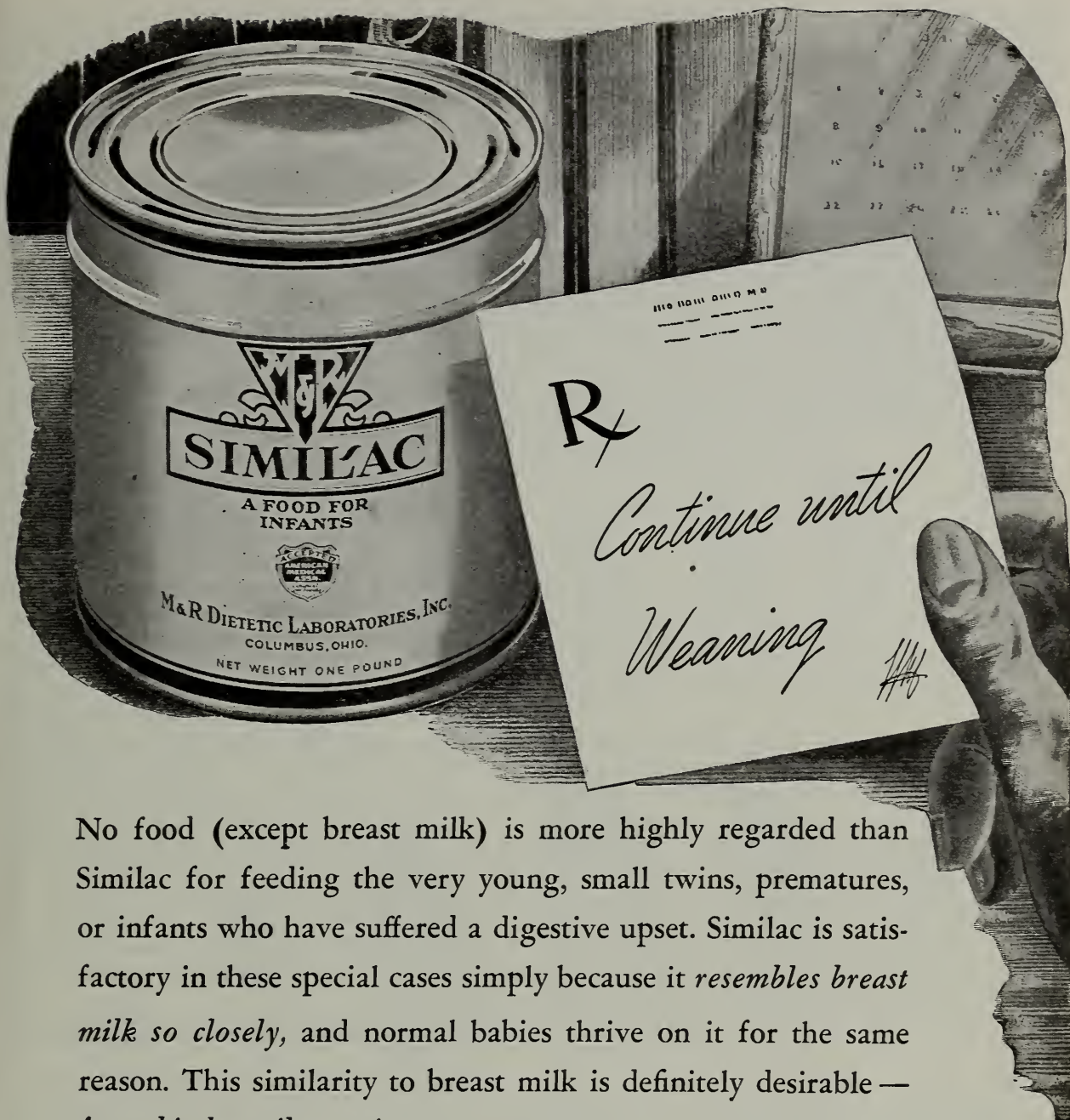
It may be argued that the military is overbuying, as evidenced by the fact that the military is making huge purchases of some medical supplies while large quantities of the same items are being sold as surplus. But, to be realistic about the matter, physicians had better apply economy to the use of film, as it is quite likely the film situation will get worse before it gets better.

The Ninth Annual Postgraduate Course in Otolaryngology, with an operative course on the cadaver, will be given at the University of Cincinnati College of Medicine, from April 13 to May 5. Details may be obtained by addressing Dr. Henry M. Goodyear, 556 Doctors Bldg., Cincinnati 2, Ohio.

\* \* \*

Absenteeism due to sickness among male industrial workers showed a substantial increase for the third quarter of 1944, sending the total industrial sickness rate in this year up to 37 per cent above the average for the period 1935-1944, according to a recent statement of the Industrial Hygiene Division of the U. S. Public Health Service.





No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely*, and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, coconut oil, corn oil, and fish liver oil concentrate.



One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

★ **SIMILAC**

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# In Memoriam

**Joseph Spangler Rardin, M.D.,** Portsmouth; Starling Medical College, Columbus, 1890; aged 83; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died March 7. One of the active leaders of medical organization in Ohio, Dr. Rardin was President of the Ohio State Medical Association in 1923, and had always been an active member of the Hempstead Academy of Medicine. A native of Athens County, he located in Portsmouth upon his graduation from medical school, and practiced there for 55 years. During World War I he was a medical officer in the U. S. Army. Dr. Rardin was surgeon for the Norfolk & Western Railway Company, and for many years was instructor of nurses at Portsmouth General Hospital. He was a past master of the Knights Templar of the Masonic Lodge and a member of the Kiwanis Club. A daughter survives.

**John Frederick Bausch, M.D.,** Ross; Miami Medical College, Cincinnati, 1907; aged 63; member of the Ohio State Medical Association and the American Medical Association; died Feb. 18. Dr. Bausch was located in Butler County for over 35 years, and had an extensive rural practice. He was a member of the staffs of Mercy and Ft. Hamilton hospitals, Hamilton, and was a medical examiner for the Butler County Selective Service Board. Dr. Bausch was a member of the Masonic Lodge and the Presbyterian Church. Surviving are his widow, a daughter, a son and a brother.

**Carl James Cannon, M.D.,** Cleveland; Cleveland-Pulte Medical College, Cleveland, 1899; aged 70; member of the Ohio State Medical Association and the American Medical Association; died March 7. Dr. Cannon practiced in Windsor, Ash-tabula County, for 14 years, moving to Cleveland in 1914. He began practice there in old Nottingham Village, and for more than 20 years operated the Nottingham General Hospital there. Dr. Cannon was a member of the Masonic Lodge and the Congregational Church. Surviving are his daughter, Dr. A. Elizabeth Cannon, Cleveland, and a sister.

**Albert Arthur Gorbold, Ross;** Miami Medical College, Cincinnati, 1897; aged 76; died March 1. Dr. Gorbold retired several years ago, after having practiced in Venice, Butler County, and in Darke County. His widow and a sister survive.

**Walton Hewetson, M.D.,** Groveport; Columbus Medical College, 1888; aged 78; died Feb. 18. Dr. Hewetson practiced in Groveport for 56 years. He was a member of the Masonic Lodge.

**James William Kautz, M.D.,** Cincinnati; Cincinnati College of Medicine and Surgery, 1890; aged 81; former member of the Ohio State Medical Association and the American Medical Association; died March 8. Dr. Kautz retired in 1941, after having practiced in Cincinnati for over 50 years. Surviving are his widow and two sons.

**Richard Roderick Marnell, M.D.,** Cincinnati; University of Cincinnati College of Medicine,

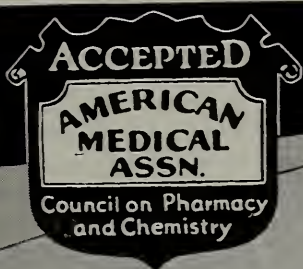
## DIED WHILE IN MILITARY SERVICE

**William Lyman Fox, M.D.,** Cleveland; Ohio State University College of Homeopathic Medicine, 1917; aged 51; member of the Ohio State Medical Association and the American Medical Association; died at An-niston, Ala., while en route to assume command of the Army Regional Hospital, Fort Bragg, N.C. A colonel in the Medical Corps of the Army of the United States, Dr. Fox had been stationed at Camp McCain, Miss. since his return from the South Pacific last August. He was a major in the Medical Corps in World War I and later practiced in Cleveland. Dr. Fox re-entered the service in March, 1941. He contracted dengue fever in New Guinea, where he was commanding officer of the 134th General Hospital. Dr. Fox was a member of the Masonic Lodge, the Rotary Club and a past-president of the Reserve Officers Association of Cleveland. His widow, a son and a daughter survive.

1933; aged 44; member of the Ohio State Medical Association and the American Medical Association; died Feb. 9. Dr. Marnell practiced in Cincinnati for 12 years. He was a member of the staffs of Good Samaritan, St. Mary and Our Lady of Mercy Hospitals. Prominent in athletics while a student at St. Xavier University, Dr. Marnell was a member of the Board of Governors of the St. Xavier Alumni Association, and for two years was one of the physicians for Xavier intercollegiate sports. He was a member of Phi Rho Sigma. His widow, four daughters, his mother, a brother and two sisters survive.

**Albert Cloyd Miller, M.D.,** Columbus; Western Reserve University School of Medicine, Cleveland, 1897; aged 72; died Feb. 10. A native of West Virginia, Dr. Miller had resided in Columbus for 34 years. He was a member of the Masonic Lodge and the Presbyterian Church. Sur-



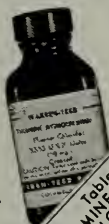


# Warren-Teed Acceptances

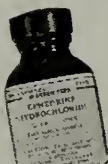
which have been announced by the American Medical Association's Council on Pharmacy and Chemistry —



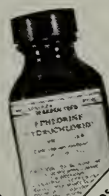
0.5 mg. Tablets  
DIETHYLSTILBESTROL



10 mg. Tablets  
THIAMINE  
HYDROCHLORIDE



25 mg. Capsules  
EPHEDRINE  
HYDROCHLORIDE



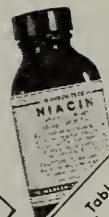
50 mg. Capsules  
EPHEDRINE  
HYDROCHLORIDE



0.5 Gm. (7.7 grs.)  
Tablets  
SULFATHIAZOLE



0.1 gm. (1 1/2 grs.)  
Tablets  
AMINOPHYLLINE



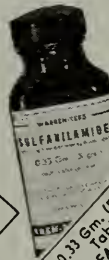
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NICOTINIC ACID



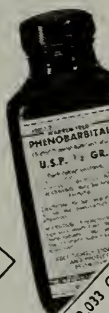
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NICOTINAMIDE



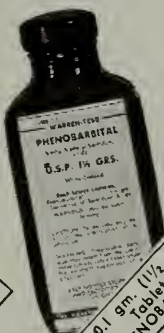
1 mg. Tablets  
RIBOFLAVIN



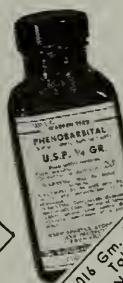
0.33 Gm. (5 grs.)  
Tablets  
SULFANILAMIDE



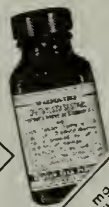
0.033 Gm. (1/2 gr.)  
Tablets  
PHENOBARBITAL



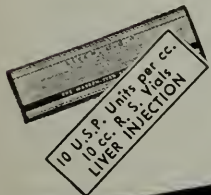
0.1 gm. (1 1/2 grs.)  
Tablets  
PHENOBARBITAL



0.016 Gm. (1/4 gr.)  
Tablets  
PHENOBARBITAL



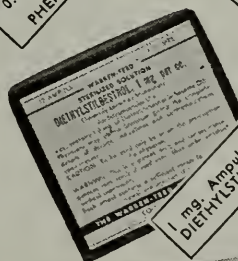
1.0 mg. Tablets  
DIETHYLSTILBESTROL



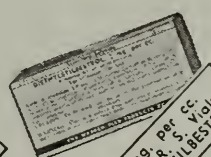
10 U.S.P. Units per cc.  
10 cc. R. S. Vials  
LIVER INJECTION



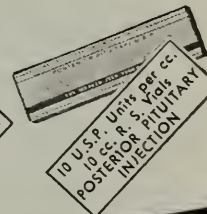
50 mg. per cc.  
15 cc. R. S. Vials  
NICOTINAMIDE



1 mg. Ampules 1 cc.  
DIETHYLSTILBESTROL



1 mg. per cc.  
15 cc. R. S. Vials  
DIETHYLSTILBESTROL



10 U.S.P. Units per cc.  
10 cc. R. S. Vials  
POSTERIOR PITUITARY  
INJECTION

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viving are his widow, a daughter, two sons and two sisters.

**Mark Millikin, M.D.,** Hamilton; Miami Medical College, Cincinnati, 1892; aged 77; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died Feb. 19. A leading member of the Butler County Medical Society for over 50 years, Dr. Millikin was chief of staff of Mercy Hospital, Hamilton, and was a member of the City Council for 12 years. He was a former president of the Butler County Medical Society, and represented the society in the House of Delegates of the Ohio State Medical Association in 1925. Surviving are his widow, a son, Capt. Neil Millikin, M.C., A.U.S., five daughters and a sister.

**Samuel DeRamus, M.D.,** Cincinnati; Meharry Medical College, Nashville, Tenn., 1918; aged 54; died March 8. Dr. DeRamus practiced in Paris, Ky. for seven years and in Cincinnati for 17 years. His widow survives.

**Clyde Leroy Smith, M.D.,** Fremont; University of Illinois College of Medicine, Chicago, 1904; aged 67; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Feb. 28. Health commissioner of Fremont for the past five years, Dr. Smith had practiced there for 38 years. He was president of the Sandusky County Medical Society in 1932. Prominent in Masonic circles, Dr. Smith was a former grand commander of the Ohio Commandery. Two daughters and a brother survive.

**Albert A. Sprague, M.D.,** Silverton, Cincinnati; Medical College of Ohio, Cincinnati, 1898; aged 83; died Feb. 19. Dr. Sprague retired in 1937, after having practiced in Silverton for 39 years. He was first clerk of the village when it was incorporated, and had been secretary of the Silverton Building and Loan Company for 40 years. Dr. Sprague was a Mason. Surviving are his widow, two daughters, a son, three brothers and two sisters.

**Franklin Leroy Sterling, M.D.,** Bowling Green, Ohio; Ohio State University College of Medicine, Columbus, 1914; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Feb. 14. Dr. Sterling practiced in Cygnet for nine years before moving to Bowling Green in 1923. He was president of the Wood County Medical Society from 1933 through 1936. Dr. Sterling was a member of the United Brethren Church, the Masonic Lodge and the Kiwanis Club. His widow, a son, a daughter and two sisters survive.

**Neile Spooner Storer, M.D.,** Republic; Northwestern University Medical School, 1906; aged

62; member of the Ohio State Medical Association and the American Medical Association; died Feb. 28. A native of Republic, where his father and grandfather were also physicians, Dr. Storer practiced in Seneca County for 38 years. He was a member of the staff of Mercy Hospital, Tiffin, and a former mayor of Republic. Surviving are his widow and a daughter.

**Stephen Tarnoczi Turney, M.D.,** Barberton; Ohio State University College of Medicine, 1931; aged 44; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Feb. 13. A native of Yugoslavia, Dr. Turney graduated in engineering at Ohio State University before he began the study of medicine. He had practiced in Barberton for 13 years. Dr. Turney was a member of the Kiwanis Club. His widow, a son and a brother survive.

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### Board Examinations Scheduled

The general oral and pathology examinations (Part II) for all candidates for certification by the American Board of Obstetrics and Gynecology will be conducted at Atlantic City, New Jersey, by the entire Board from Thursday, June 14, through Tuesday, June 19. The Hotel Shelburne in Atlantic City will be the headquarters. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the hotel. Candidates for reexamination in Part II must make written application to the Secretary's Office not later than April 15, 1945.

The Office of the Surgeon-General (U.S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to detached duty for the purpose of taking these examinations whenever possible. Candidates in Military or Naval Service are requested to keep the Secretary's Office informed of any change in address.

Deferment without time penalty under a waiver of published regulations applying to civilian candidates, will be granted if a candidate in service finds it impossible to proceed with the examinations of the Board.

Applications are now being received for the 1946 examinations. For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pa.

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The executive board of the American Public Health Association has voted to postpone the 74th annual meeting of the association, scheduled to be held in Chicago, the week of September 17.



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• Yes . . . and in Paterson, Portland, Pittsburgh and Pocatello . . . for this new antibiotic is now being distributed through the same channels which make other Parke-Davis prescription products available to the physicians and pharmacists of the country. In the short space of five years Penicillin has developed from a mold on a petri dish in a London laboratory to a package on the shelves of the prescription rooms of fifty odd thousand retail pharmacies throughout the United States.

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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### CLINTON

Dr. Wm. L. Wead spoke on "Present Status of Penicillin Therapy", at a well-attended luncheon meeting of the Clinton County Medical Society, March 6, at Wilmington.—R. W. DeCrow, M.D., secretary.

### BUTLER

"Principles of Reconstructive Surgery", was the topic discussed by Dr. V. E. Siler, Cincinnati, at a meeting of the Butler County Medical Society, Feb. 22, at the Middletown Hospital.—Garret J. Boone, M.D., president.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during March:

March 6—"Physiological and Clinical Studies Dealing with Anti-Thyroid Drugs", Dr. R. H. Williams, assistant professor of medicine, Harvard University Medical School, Boston, Mass.

March 20—Joint meeting with the Nutrition Council. "Field Testing of Emergency Rations", Major William B. Bean, M.C., Fort Knox, Ky.; "Beriberi Heart Disease in the Cincinnati General Hospital", Dr. Carl F. Vilter, Cincinnati.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### MONTGOMERY

James Cassidy, Cincinnati, NBC and WLW war correspondent and radio commentator, related some of his experiences at a meeting of the Montgomery County Medical Society, March 2, at St. Elizabeth Hospital, Dayton.—C. J. Derby, M.D., president.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### ALLEN

Officers of the Academy of Medicine of Lima and Allen County for 1945 are: Dr. Donald W. English, president; Dr. Chas. L. Steere, vice-president; Dr. Chester Badertscher, secretary; Dr. M. A. Mulvania, treasurer; Dr. E. C. Yingling, chmn., Legislative Committee; Dr. J. R. Tillotson, chmn., Committee on War Participation; Dr. John E. Talbott, chmn., Committee on Industrial Health.

### HANCOCK

Dr. Harry E. LeFever, Columbus, of the Department of Neurosurgery, Ohio State University College of Medicine, spoke on "Diagnosis and Treatment of Pathological Lesions of In-

tervertebral Discs", at a meeting of the Hancock County Medical Society, March 9, at the Elks' Club, Findlay.—Lena S. Enright, M.D. secretary.

### SENECA

The following Tiffin physicians are officers of the Seneca County Medical Society for 1945: Dr. R. F. Machamer, president; Dr. W. R. Funderburg, vice-president; Dr. R. E. Schriener, secretary-treasurer; Dr. E. F. Ley, chmn., Committee on Industrial Health; Dr. Funderburg, chmn., Committee on Recreation and Physical Fitness.

### WYANDOT

Officers of the Wyandot County Medical Society for 1945 are: Dr. J. Craig Bowman, Upper Sandusky, president; Dr. R. J. Semons, Carey, vice-president; Dr. L. W. Naus, Upper Sandusky, secretary-treasurer; Dr. Franklin M. Smith, Sycamore, chmn., Legislative Committee; Dr. B. A. Moloney, Upper Sandusky, chmn., Committee on War Participation; Dr. Semons, chmn., Committee on Industrial Health; Dr. R. L. Garster, Upper Sandusky, chmn., Committee on Physical Fitness.

## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### LUCAS

The Academy of Medicine of Toledo presented the following programs during March:

March 2—General Meeting. Clinico-Orthopedic Conference, by the orthopedic staff of St. Vincent's Hospital, Dr. B. J. Hein, director of orthopedic service, assisted by Drs. Burt Chollett, Thomas Brown, Paul Hohly, Rudolph Diethelm, O. W. Burkholder and Rollin Kuebbeler.

March 9—Section of Pathology, Experimental Medicine and Bacteriology. "The Histologic Origin of Cancer", Dr. Bernhard Steinberg.

March 16—Medical Section. "Bone Marrow in Diagnosis", Dr. Foster Myers.

March 23—Surgical Section. "Surgical Aspects of Thyroid Diseases", Dr. George Bates; "Thiouracil, as Used in the Management of Thyroid Disease," Dr. D. Scheer.

March 30—Eye, Ear, Nose and Throat Section. "Diagnosis and Treatment of External Diseases of the Eye", Dr. J. H. Cooper; "Some Interesting Case Presentations of Foreign Bodies in the Food and Air Passages", Dr. W. W. Randolph.—Bulletin.

### OTTAWA

The Ottawa County Medical Society has re-elected the following officers for 1945: Dr. A. S. Mack, Oak Harbor, president; Dr. W. R. Gibson, Oak Harbor, vice-president; Dr. George



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A. Boon, Oak Harbor, secretary-treasurer; Dr. E. D. Schuiteman, Genoa, chmn., Legislative Committee.

#### SANDUSKY

Officers of the Sandusky County Medical Society for 1945 are: Dr. J. C. Boyce, Fremont, president; Dr. A. F. Shultz, Fremont, vice-president; Dr. R. C. Fox, Green Springs, secretary-treasurer; Dr. E. A. Baker, Clyde, chmn., Legislative Committee; Dr. C. I. Kuntz, Fremont, chmn., Committee on War Participation; Dr. J. W. Agnew, Gibsonburg, chmn., Committee on Industrial Health; Dr. E. C. Swint, Fremont, chmn., Committee on Recreation and Physical Fitness.

#### Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

#### CUYAHOGA

The following program was presented at a meeting of the Pediatric Section of the Cleveland Academy of Medicine, Mar. 21: "Lipemic Nephrosis", Dr. Walter Heymann; "Vaginal Discharges of Childhood", Dr. J. D. Pilcher; "Isolation of Poliomyelitis Virus from Creek Water", Dr. John A. Toomey.—Bulletin.

#### Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

#### COLUMBIANA

Officers of the Columbiana County Medical Society for 1945 are: Dr. J. W. Schoolnic, East Liverpool, president; Dr. F. R. Crowgey, Salem, vice-president; Dr. Chas. A. Gerace, East Liverpool, secretary-treasurer.

#### PORTAGE

The Portage County Medical Society omitted its March meeting to join with the Summit County Medical Society at a meeting in Akron, March 6, which was addressed by Dr. P. S. Pelouze, assistant professor of urology, University of Pennsylvania. His subject was: "Diagnosis and Management of Gonorrhea". This was one of a series of meetings throughout the state sponsored by the Ohio State Medical Association and the State Department of Health.—Emily Widdecombe, M.D., secretary.

#### STARK

Officers of the Stark County Medical Society for 1945 include: Dr. A. R. Basinger, North Canton, president; Dr. L. E. Leavenworth, Canton, president-elect; Dr. L. E. Anderson, Greentown, secretary-treasurer; Dr. G. N. Wenger, Massillon, chmn., Legislative Committee.

#### SUMMIT

"Diagnosis and Management of Gonorrhea", was the subject of an address made by Dr. P. S.

Pelouze, assistant professor of urology, University of Pennsylvania, at a meeting of the Summit County Medical Society, March 6, at Akron.—Bulletin.

#### Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

#### FAIRFIELD

Officers of the Fairfield County Medical Society for 1945 are: Dr. C. B. Crow, Lancaster, president; Dr. S. C. Sneeringer, Baltimore, vice-president; Dr. C. W. Brown, Lancaster, secretary-treasurer; Dr. C. G. Axline, Lancaster, chmn., Legislative Committee; Dr. C. H. Hamilton, Lancaster, chmn., Committee on War Participation; Dr. C. B. Snider, Lancaster, chmn., Committee on Industrial Health.

#### MUSKINGUM

Dr. P. S. Pelouze, assistant professor of urology, University of Pennsylvania, Philadelphia, spoke on "Diagnosis and Management of Gonorrhea", at a meeting of the Muskingum County Academy of Medicine, March 5, at the Zane Hotel, Zanesville.—Beatrice T. Hagen, M.D., secretary.

#### WASHINGTON

Officers of the Washington County Medical Society for 1945 are: Dr. W. E. Radcliff, Caldwell, president; Dr. E. W. Hill, Jr., Marietta, vice-president; Dr. M. S. Muskat, Marietta, secretary-treasurer; Dr. S. E. Edwards, Marietta, chmn., Legislative Committee; Dr. J. A. McCowan, Marietta, chmn., Committee on War Participation; Dr. J. B. Penrose, Marietta, chmn., Committee on Industrial Health; Dr. G. E. Huston, Lowell, chmn., Committee on Recreation and Physical Fitness.

#### Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

#### JACKSON

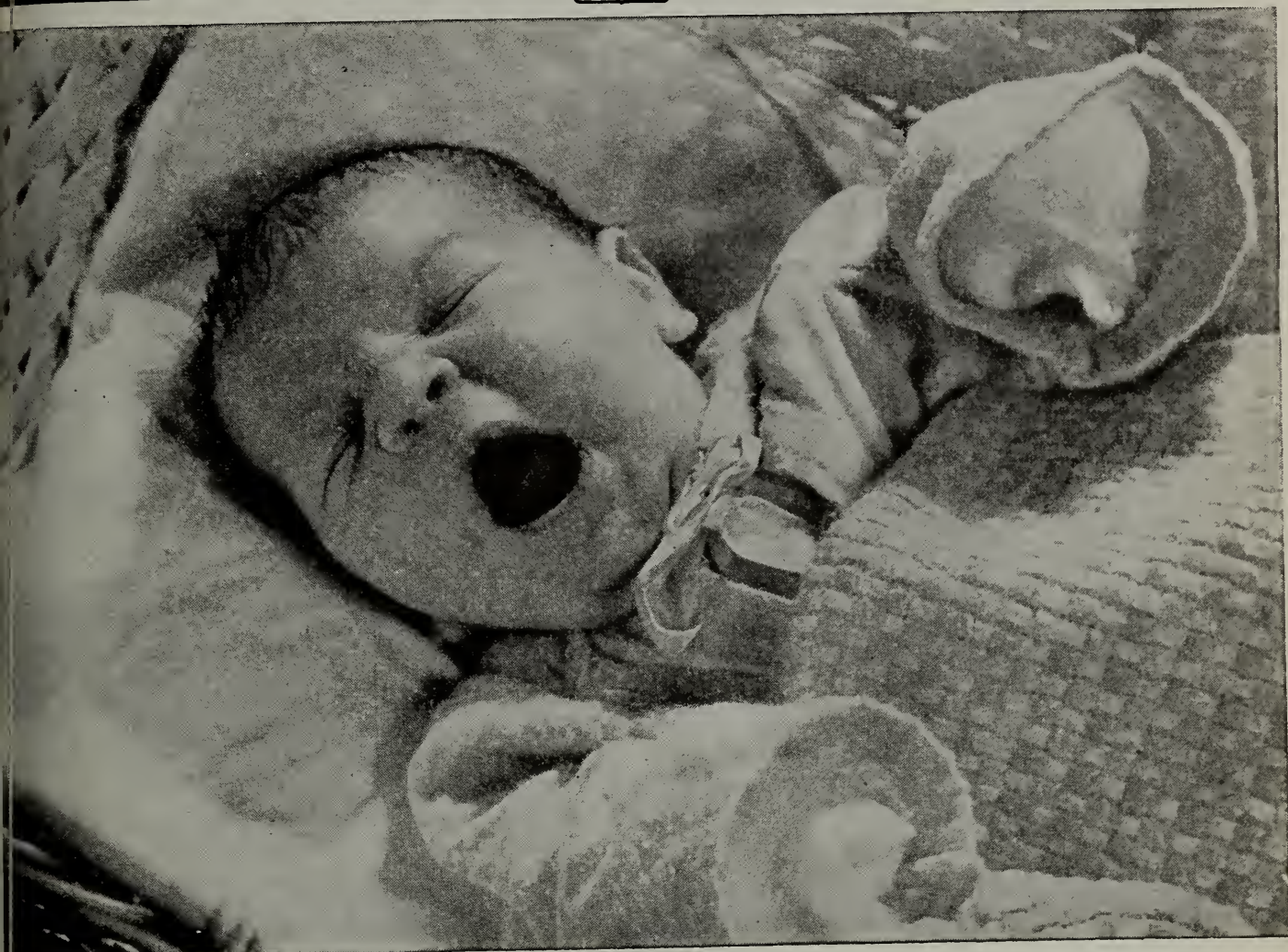
Officers of the Jackson County Medical Society for 1945 are: Dr. John L. Frazer, Wellston, president; Dr. C. C. Fitzpatrick, Jackson, vice-president; Dr. W. B. Taylor, Jackson, secretary-treasurer; Dr. H. W. Gillen, Wellston, chmn., Legislative Committee; Dr. Mel D. Smith, Wellston, chmn., Committee on War Participation; Dr. G. A. Parry, Jackson, chmn., Committee on Industrial Health; Dr. B. J. Allison, Oak Hill, chmn., Committee on Recreation and Physical Fitness.

#### LAWRENCE

The following Ironton physicians are officers of the Lawrence County Medical Society for 1945: Dr. H. S. Allen, president; Dr. V. V. Smith, vice-president and chmn., Committee on War Participation and Committee on Industrial



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Health; Dr. R. F. Massie, chmn., Legislative Committee.

## Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

### FAYETTE

The Fayette County Medical Society has elected the following officers for 1945: Dr. J. H. Persinger, Washington C.H., president; Dr. E. H. McDonald, Washington C.H., vice-president; Dr. O. L. Wiseman, Jeffersonville, secretary-treasurer; Dr. A. D. Woodmansee, Washington C.H., chmn., Legislative Committee.

### FRANKLIN

The Columbus Academy of Medicine presented the following programs during March:

March 5—"Prevention of Late Postpartum Morbidity", Dr. Zeph J. R. Hollenbeck, with discussion by Dr. Robert Daly and Dr. Wynne M. Silbernagel.

March 15—Special Meeting. "Diagnosis and Management of Gonorrhea", Dr. P. S. Pelouze, Philadelphia.

March 19—"Detection and Treatment of Tuberculosis", Dr. Myron D. Miller, with discussion by Dr. Louis Mark.—Bulletin.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### LORAIN

Dr. Edward Goodsitt, Cleveland, spoke on "The Development of a Blood Bank for a General Hospital", at a meeting of the Lorain County Medical Society, March 13, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

## WOMAN'S AUXILIARY NEWS

(By MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### BUTLER

A luncheon meeting of the Woman's Auxiliary to the Butler County Medical Society was held in the Oval Room of Hotel Manchester, Middletown, on February 24. The president, Mrs. Harry Burdsall, presided. Thirty-five members from Hamilton, Oxford and Middletown were present. Mrs. E. Norwood Clark, hostess chairman, was assisted by Mrs. Melvin Fishman, Mrs. E. O. Bauer, Mrs. Mártin Decker, Mrs. Ross Hill, Mrs. E. McCall Morris, Mrs. Russell Pierson and Mrs. M. H. Weinstein. Prior to the business session, a two-part program was presented. Mrs. H. D. Wren, violinist, accompanied by Mrs. H. H. Belknapp, pianist, offered several appropriate selections. Mrs. Florence Worrell, General Secretary, of the Hamilton Y.W.C.A., gave an interesting book review on "Anything Can Happen". The

next regular meeting will be Tuesday, April 24, at the residence of Mrs. C. I. Stafford, Oxford.

### FRANKLIN

Dr. Howard Mitchell, Chairman of the Advisory Committee of the Woman's Auxiliary to the Columbus Academy of Medicine, and wives of Army doctors stationed in Columbus, were honor guests at a luncheon, March 1, at the Fort Hayes Hotel. Fifteen-minute talks were given by Dr. George Heer, President of the Academy of Medicine, and Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association. Bridge followed the luncheon. Hostesses for the meeting were: Mesdames A. B. Landrum, I. B. Harris, S. J. Goodman, Earl Baxter, E. T. Bonar, R. R. Kahle, Cornelius Landen, Earl Peinert, Lester Seligson, H. D. Wright, E. G. Klopfer, Fred Fletcher, C. W. McGavran, W. D. Inglis, Eugene Beam, George Bonnell, Henry Karrer, Ernest Parrett, W. L. Pritchard, and Clark E. Sharp.

The 1945 Annual Meeting of the Woman's Auxiliary, Ohio State Medical Association, which had been scheduled for Columbus, May 1, 2 and 3, has been cancelled in compliance with the request of the U. S. Office of Defense Transportation.

A two-day meeting of the Board of Directors of the Auxiliary will be held at the Deshler-Wallick Hotel, Columbus, on April 18 and 19, at which time some of the business which would have been taken up at the Annual Meeting will be transacted.

### MARION

The February meeting of the Woman's Auxiliary to the Marion Academy of Medicine was held at Hotel Harding. The president, Mrs. J. A. Dodd, presided. Announcement of the gift of a Hess Infant Incubator and Oxygen Unit to the City Hospital by the Woman's Auxiliary to the Marion County Academy of Medicine was made. The hospital committee is composed of Mrs. Weinbaum, Mrs. Sawyer and Mrs. Smyth. After luncheon the group sewed for the Cancer Clinic and made plans for a rummage sale under the direction of Mrs. Bull. March 17 is the date of the next regular meeting.

### RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met March 5, at the Women's Club, Mansfield, for a dessert luncheon. Hostesses were Mrs. John Hattery and Mrs. Frank Maxwell. Following luncheon, Mrs. Leopold Adams conducted the business meeting, during which Mrs. J. F. Morey gave a report on surgical dressings made for the hospital. Mrs.



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—New and Unofficial Remedies:  
Allergic Preparations, Chicago,  
American Med. Assoc., 1944, p. 56.



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W. E. Wygant announced a Bond Drive beginning in May. Mrs. R. D. Campbell spoke on "Medical Service Plans" and commented upon such plans operating in several states.

#### ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine, Chillicothe, held a dinner meeting March 1. Thirteen members and guests, Mrs. Charles Hoyt, Mrs. Nicholas Holmes, and Mrs. M. M. Berry were present. The business meeting was conducted by the president, Mrs. Walter C. Breth. Plans were discussed for raising funds to purchase an incubator for Chillicothe Hospital. Mrs. Berry, guest speaker, gave an illustrated talk on areas now in the war news that she visited in 1938.

#### SENECA

The Woman's Auxiliary to the Seneca County Medical Society met at the residence of Mrs. W. R. Funderburg, Tiffin, on February 22. Mrs. Edmund Ley, retiring president, opened the business session and turned the meeting over to Mrs. Funderburg, incoming president. Contract bridge was enjoyed with refreshments served by the hostess and Mrs. M. H. Aiken.

#### SCIOTO

The Woman's Auxiliary of the Hempstead Academy of Medicine, Portsmouth, met at the residence of Mrs. Frank Beeks, February 14. Officers were elected as follows: Mrs. William Singleton, president; Mrs. Frank Seidenburg, president-elect; Mrs. Hubert Thurman, vice-president; Mrs. George Obrist, secretary; Mrs. G. E. Neff, treasurer; Mrs. W. C. McCann and Mrs. W. A. Ray, board members. At the suggestion of Mrs. T. C. Crawford, the members voted to furnish lunches for their sponsored orthopedic class. During the social hour, Mrs. Clyde Fitch related "The Legend of Saint Valentine's Day". Refreshments were served by the hostess assisted by Mrs. C. L. Ferguson, Mrs. T. G. McCormick, Mrs. Milton Levine, Mrs. R. P. Elder, Mrs. J. W. Hutchens and Mrs. J. T. Murchie.

Dr. Edward J. McCormick, Toledo, vice chairman of the Council on Medical Service and Public Relations of the American Medical Association, is scheduled to be one of the speakers at three A.M.A. regional conferences to be held at Portland, Ore., April 7; San Francisco, April 10 and Los Angeles, April 13.

\* \* \*

The lead article in the March issue of *The Journal of the Indiana State Medical Association*, which was dedicated to the physical fitness program, was "A Medical Viewpoint on National Fitness", by Dr. John W. Wilce, Director of the Student Health Service, Ohio State University, Columbus.



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# WAR NOTES

According to an announcement from the Surgeon General's Office, Army medical officers who have been occupied with administrative and other non-professional duties and who are to be assigned professional duties will be offered the opportunity to take refresher professional training under a new program just inaugurated by the Army Medical Department.

This training, which will be voluntary, will be open to members of the Medical Corps who, because of assignment to command, administrative or semi-professional positions have not engaged in the professional aspects of medical service during the past twelve months or more. Priority will be given those who have served overseas.

Requests for this training will be submitted through channels to The Surgeon General who will make assignments to the general and regional hospitals where the courses will be given. Officers selected will go on temporary duty for a period of not more than 12 weeks.

\* \* \*

**Capt. Peter A. Volpe, Columbus, wounded while in action in Germany with an armored division, is a patient at Wakeman General Hospital, Camp Atterbury, Ind.**

\* \* \*

Malaria control officer along the Ledo Road is the interesting assignment of Capt. John A. Carter, Middletown.

\* \* \*

Capt. J. B. Kallenberg, Cincinnati, with an engineer construction group at Luzon in the Philippine Islands, had an opportunity to talk with the first batch of American prisoners of war who were rescued in the now historic raid by daring American Rangers. Here are some of the interesting things he learned:

"1. Medical attention was excellent after field hospital unit No. 1 was brought up from Bataan, though supplies were meager.

"2. Escape, though possible, was rarely undertaken, for the hills were worse than the camp, especially for living, diseases, etc.

"3. Beri-beri and vitamin deficiencies were most prevalent, and swelling of feet and poor vision greatest handicaps.

"4. They lived in nipa (straw shacks), former Filipino barracks built to house two per day, but seven or eight Americans were crowded in each.

"5. Contrary to general belief, the Jap private

is clean, bathing two and three times daily. They expected the Americans to do likewise and therefore gave them Filipino cocoanut and lye soap which had to be washed off rather quickly.

"6. A peculiar episode was that in a two-week period (which was some three years after internment) almost all the prisoners developed 'drooped neck and eyelids'. They'd feel fine and suddenly the head would drop on the chest and the person just couldn't lift it, nor control the drooping of the eyelids. This had the M.C.'s stumped, but just about this time rations improved—so what was it? Probably a B complex deficiency.

"7. Malignant(?) malaria and pneumonia killed off most in groups as in work details away from camp, but tuberculosis and malnutrition took their daily toll."

\* \* \*

Here and there within the United States: Capt. Ralph W. Tapper, Dayton, Sta. Hosp., Baer Field, Ft. Wayne, Ind.; Capt. Joseph H. Bolotin, Warren, 21st Med. Serv. Co., Ft. Lewis, Wash.; Capt. A. D. Robertson, Willard, A.A.F. Conv. Center, Ft. Thomas, Ky.; Maj. Clarence T. Risley, Conneaut, Reg. Hosp., Langley Field, Va.; Lt. Comdr. Leonard J. Newell, Dayton, Mar Fair West, M.C.A.D., San Diego, Calif.; Lt. Aaron S. Canowitz, Columbus, 242nd Gen. Hosp., Camp Barkeley, Texas; Maj. Richard T. Sauer, Dayton, 1570 S.U., Camp Breckinridge, Ky.; Maj. Asher Randell, Youngstown, 314th Gen. Hosp., Ft. Lewis, Wash.; Capt. Philip Katz, Toledo, Reg. Hosp., Robins Field, Ga.; Capt. Joseph M. Miller, Marion, 401 Thoracic Surgery Detachment, Ft. Lewis, Wash.; Capt. J. P. McAfee, Portsmouth, Kelly Field, Texas; Capt. Francis X. L. Baurichter, Cincinnati, P.O.W.C., Alva, Okla.; Maj. Jack A. Adelman, Columbus, 1040 A.A.F.-B.U., Santa Ana, Calif.; Maj. W. E. Brogden, 1078 A.A.F.B.U., Richmond, Va.; Capt. David R. Lewis, Grove City, Reg. Sta. Hosp., Barksdale Field, La.; Maj. John T. Crone, Milford, 3614 S.U. Hqs., Vaughan Gen. Hosp., Hines, Ill.; Maj. Samuel Lobe, Cincinnati, Nichols Gen. Hosp., Louisville, Ky.; Maj. Paul McConnell, Youngstown, Reg. Hosp., Camp Barkeley, Tex.

\* \* \*

Three years in the Southwest Pacific hasn't affected the sense of humor of Maj. J. Henry Lazzari, Cleveland, originally with the Lakeside Unit, later stationed on an Army hospital ship,



and now chief of surgery for a general hospital in New Guinea. He writes:

"Like all other Ohioans, I read *The Journal* with especial interest when it arrives in the mail. This time I read the copies received by Joe Hertzberg of Toledo, who is chief of general surgery here. Since I am chief of surgery I am his boss so I make him submit *The Journals* to me first. Of course he cries about this but we must recognize rank, you know.

"Anyway, in the October issue you still had me on the Hospital Ship *Tasman* and I thought it would be nice to send in my new address so if any of the doctors wanted to refer me cases they would know where to find me. Therefore, I am Chief Surgeon at the (X) General. Other Ohioans are Hertzberg and Irvin Liebow of Cleveland. Col. Hans Lawrence (Fisher Body, Cleveland) was base surgeon here but he has gone on to the Philippines. There are Ohio men up and down the New Guinea coast and you cover the news very well. I dare say that your military section is appreciated by men overseas far more than you even suspect. I would not be too surprised if some of them read that department before they read the stuff on paranoia."

\* \* \*

Captioned "Alliterative Account of Armored Action", is the following newspaper account of the activities of the outfit, of which Capt. S. E. Gates, Conneaut, is battalion surgeon:

"The 60th Armd. Inf. Bn. is alliterative and brief in its summary of action during the German counter-offensive. The battalion's account: 'Battered bastards battled from Beaufort and Bigelback to bastion of Bastogne on Belgian border in Battle of the Bulge.'

"The 60th, a Ninth Armd. Div. unit, held the Germans for ten days near Waldbillig, Luxembourg, and was cut off part of the time. After a night-long march, the outfit participated with the Fourth Armd. Div. in opening the Neufchateau-Bastogne corridor."

\* \* \*

(Confidentially, your War Notes reporter is somewhat partial to the Armored Force, because his own kid, Sgt. Edward F. Saville, is a tank commander, "Somewhere in France".)

\* \* \*

Maj. Wm. F. Ashe, Cincinnati, assistant director, Nutrition Division, Preventive Medicine Service, represented the Office of The Surgeon General at a meeting of the Macy Foundation in New York City on February 2 and 3. The topic of discussion was "The Metabolic Aspects of Convalescence".

\* \* \*

There are currently 74 women medical officers serving in the Army, according to the Office of The Surgeon General. Of this number four are majors, 36 are captains and 34 are first lieutenants. They have been certified as internists, neuropsychiatrists, obstetricians, gynecologists,

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pathologists, radiologists and anesthetists, and the Army has given them assignments in line with their specialties at general, regional and station hospitals as well as at the two WAC training centers. Seventeen of these women medical officers are now serving overseas.

\* \* \*

Maj. Robert C. Haubrich, Pataskala, surgeon for a bombardment group in the Marianas, comments: "I have been on every d— island in the Central Pacific in my 20 months overseas and can truthfully say that I and most everyone else will be glad to see a big piece of land. We have had many exciting times here with the Japs coming over often enough to keep our interest at full ebb, sometimes high and sometimes low. Personally, I'll take the high."

\* \* \*

Also on the Marianas, with an air service group general hospital, Capt. Louis L. Weiss, Canton, has this to report: "The general hospital, recently established on this island, has started a program of very interesting weekly staff conferences. This is my first taste of medical meetings since leaving Honolulu almost six months ago. Dengue cases, which were the predominant illness when we arrived, are practically non-existent now. There is no malaria, yaws, or filariasis. Natives have plenty of bacillary and amebic dysentery, and hookworm disease. Soldiers are picking up these conditions gradually from the natives, even though native villages are 'Off Limits' to troops. We are slowly becoming civilized. There is already a beautiful network of asphalt paved highways on the island. We have electricity, screened-in, wooden-floored tents, nightly movies, occasional fresh meat and fruit. Quite a difference from conditions four months ago. No, we're not wearing neckties yet."

\* \* \*

Starting his fifth year of active Naval service, Comdr. Stanley Gardner, Cleveland, who has been in charge of the anesthesia department in a large hospital in Hawaii, was recently transferred to the U.S. Naval Hospital, Corvallis, Oregon.

\* \* \*

From "Somewhere in Germany", Maj. Gregory G. Floridis, Dayton, has this to say: "Your encouraging letter and my card to membership in your esteemed organization have just been received. *The Ohio State Medical Journal* regularly—like German 88's—comes to visit me in the Siegfried Line, where I work at present as regimental surgeon with an infantry regiment. Living in basements of torn German houses by



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candlelight and doing our best for the American wounded doughboy has its compensations, and I would not ask for any better assignment. It has been my privilege to train my medical detachment in the States and be with them through all experiences. The heroic work of these men is the pride of the regiment. I join many others in thanking you for *The Medical Journal* that gives us a lingering touch of all the fine things we left back home."

\* \* \*

Maj. E. E. Lyon, Toledo, has been awarded the Soldier's Medal for heroism. He rescued two soldiers from drowning when a landing craft overturned during a landing operation in the Southwest Pacific.

\* \* \*

Recently a surgeon at a Naval base hospital in the Marianas, Lt. Comdr. Sterling W. Obenour, Zanesville, is now on sea duty. In the service since Oct. 19, 1942, he has been on duty in Naval hospitals at Treasure Island, Calif., and Norfolk, Va.; and at the Marine Base, Quantico, Va.

\* \* \*

Col. Will L. Pyles, who was Surgeon of the Fifth Corps Area, Fort Hayes, Columbus, at the time of his retirement from the Army in 1942, died in New York City, March 12, at the age of 67, after a long illness.

\* \* \*

The Army's expansion of its general hospitals by 70,000 beds is being rapidly accomplished through the conversion of existing buildings on hospital grounds rather than through new construction, according to the Office of The Surgeon General.

\* \* \*

"The 11th Field Hospital is a model for new hospital units coming into this area", writes a war correspondent in a news dispatch from Southern France. The commanding officer of the 11th is Lt. Col. Herman E. Wilkinson, Van Wert. Col. Wilkinson is quoted, in part, as follows: "The surgeons who are operating in the field are going to a warborn school no one ever

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dreamed would exist. . . . Out of the experience in these field hospitals will come surgical experts the like of whom the world never has seen before." The hospital unit has been awarded a meritorious service unit plaque for its work from D-day in southern France last Aug. 15 to Nov. 30, chiefly in supporting the 45th and 36th Infantry Divisions' clearing stations. Most of its recent activity has been in the Colmar pocket in support of the XXI Corps, according to the news story.

\* \* \*

For meritorious service during the "break-through" in France, the unit with which Capt. Maurice E. Scheetz, Kalida, is attached, received the Presidential Citation. He is now with a clearing station, after having been in an engineering battalion.

\* \* \*

Capt. Ralph J. Starbuck, Salem, "somewhere in Burma", has this to say in a letter acknowledging receipt of his 1945 membership card: "Liaison squadrons are doing a great job over here, flying out the wounded from the front lines, and their work is really appreciated by those men fighting on the ground. Malaria is fairly well licked, dysentery not too common \* \* \*."

\* \* \*

Lt. Comdr. Paul Kellogg, Ashland, medical officer on a ship out in the Pacific, has for one of his pharmacist mates another Ohioan named Reese, from Shelby.

\* \* \*

Maj. Harold F. Wherley, Stone Creek, who was on the staff at the Station Hospital, Ft. Hayes, for three years, is doing E.E.N.T. with a general hospital in England. He reports that Maj. Robert T. Allison, Jr., Akron, is doing top-notch work as chief of surgery.

\* \* \*

Capt. R. E. Tschantz, Canton, now at the Station Hospital, Boca Raton A. A. F., Fla., says his Ohio State Medical Association membership card was his only means of identification in getting a check cashed while in London, and further, that it was better than his Army identification card.

\* \* \*

Col. Derrick T. Vail, Cincinnati, Senior Consultant in ophthalmology for the European Theater of Operations since 1942, has been assigned as Chief of the Ophthalmology Branch, Surgical Consultants Division, Office of The Surgeon General. He replaces Lieutenant Colonel

Middleton E. Randolph, MC, who has been assigned as chief of the Eye, Ear, Nose and Throat Section of Valley Forge General Hospital, Phoenixville, Pa. Col. Vail has also been designated S.G.O. liaison officer with the Committee on Sensory Devices, Office of Scientific Research and

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Development, S.G.O. liaison officer with the Army-Navy-O.S.R.D. Vision Committee, and S.G.O. liaison officer with the Committee on Ophthalmology, National Research Council.

He is well known in civilian medical circles as Editor-in-Chief and Manager of the *Journal of Ophthalmology*, from which he is on leave, and for his work at the University of Cincinnati where he was professor of ophthalmology and director of that department.

Northwestern University, Chicago, Ill., has just appointed Col. Vail professor and director of the department of ophthalmology, granting him leave until after the war, according to a news release from the S.G.O.

\* \* \*

Comdr. A. Reese Klopfenstein, Toledo, is commanding officer of a Navy hospital which was in operation on Saipan two days after their initial landings, according to an overseas dispatch from the U.S. Marine Corps. For his share in this achievement, Dr. Klopfenstein has been awarded the Bronze Star Medal, which was personally pinned on him by Marine Lieut. Gen. Holland M. Smith.

\* \* \*

"Playing stork" to the dependents of military personnel in and about Temple, Texas, and "doubling in brass" on boards, committees, etc., is the assignment of Maj. J. K. Hoerner, Dayton, at McCloskey General Hospital, Temple, Tex. He says that Capt. Thomas B. Wayman, Cincinnati, is chief of the Urological Branch, and is doing a fine job for the government.

\* \* \*

Capt. John P. Urban, Columbus, squadron surgeon with a B-24 outfit in England for over a year, says he is ready to come back home any time now, a thought which recurs in many of the communications received at the State Headquarters Office from Ohio medical officers overseas—and in the states.

\* \* \*

A member of the Division of Hospitalization, Department of Medicine, of the A.A.F. School of Aviation Medicine, Randolph Field, Texas, Capt. Raphael N. Paul, Dayton, was recently promoted to his present rank.

\* \* \*

After being in England for a few months, Capt. Wendell A. Parker, Cleveland, reports that he has been in Iceland for the past year, on the surgical service of a station hospital.

\* \* \*

Out in Dutch New Guinea, where he is on the staff of a general hospital, Maj. Harold G. Beeson, Wooster, reports that he receives *The Journal* regularly.

\* \* \*

Here are some observations made by Capt. J. R. Seesholtz, Toledo, on the campaign in the Philippines: "At present the field hospital I am

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with is set up in an old school house and we have been getting more than our share of casualties. It's been a tough sector and all four of our operating tables have been busy for stretches of 20-23 hours. That's a sight to see—four tables in one large room—all constantly occupied. One doesn't mind the long hours though in helping these men of ours. Never saw such brave, unselfish chaps in all my life.

"These Philippines are surely an experience after a year in the jungle. Civilization is wonderful! To see paved roads, to hear English spoken, to watch children on their way to school and to experience the happy welcome from them, all helps to put more reason as to 'why' we are here.

"Have seen Cpts. Clarke and Zeno of Mansfield and Akron. Zeno is attached temporarily to us for this campaign."

\* \* \*

Lt. Comdr. Wm. B. McAllister, Jr., Cleveland Heights, has been awarded the United States of America Typhus Commission Medal for "exceptionally meritorious service" in control of typhus.

\* \* \*

After a short tour of duty in the Central Pacific, Lieut. Harry Morris, U.S.N.R., Cleveland, is back in the States examining hearts of Alabamians at the Armed Forces Induction Station, Fort McClellan, Ala., and while the assignment is important, he'd rather be "in a combat or more forward area".

\* \* \*

Maj. Robert D. Snyder, Dayton, chief of surgery, with a field hospital in France, reports a new A.P.O., with the comment: "It seems our A.P.O. changes every time it rains, and we are in a wet season now". Associated with him are the following Buckeyes: Maj. H. H. Ipp, Youngstown, his roommate and chief of medicine; Capt. Paul Chrenka, Cleveland, radiologist; Capt. David Goodman and Lieut. Edward Humel, Cleveland, assigned to internal medicine.

\* \* \*

"For the benefit of the M. D.'s who served in the last war, France has not changed as to its customs and ideas", V-mails Maj. Wilford C. Lacock, Beaverdam, who landed on D-2 with one of the first, if not the first field hospital in France. Since then he has traveled across France, Belgium and into Germany. He did manage to see Paris for a few hours, also Brussels. The next capital on your itinerary is no doubt Berlin, Major, and here's hoping you attain that objective soon.

\* \* \*

Capt. Phillip B. de Maine, Akron, flight surgeon with a troop carrier squadron stationed in England, has been around a good bit in the United Kingdom and on the Continent and even had a

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trip back to New York last July evacuating patients by air. He is ready for another flight back to the States any time. Capt. de Maine has seen a lot of Ohio physicians, and suggests a State Society meeting over there. Good idea, doctor—and better yet, how's for the Woman's Auxiliary meeting concurrently?

\* \* \*

To Maj. William T. Vaughn, Akron, goes the distinction of being the first member of the Summit County Medical Society to win the Bronze Star Medal. The citation accompanying the award, signed by Maj. Gen. A. D. Bruce, commanding the 77th infantry division, reads "for meritorious service in connection with military operations against the enemy on Leyte, P. I., from December 7 to December 18, 1944. During this period Maj. Vaughn, both as commanding officer and surgeon of the hospital, worked tirelessly and unceasingly. He participated in over 100 surgical operations, often operating under aerial attack and artillery bombardment. He worked day and night without consideration of his personal comfort or safety, and was a constant source of inspiration to his men."

\* \* \*

Conversations with a village doctor in England regarding the private practice of medicine in that country makes Lt. Col. George L. Hardgrove, Doylestown, "most grateful that I can hope to return to Ohio eventually". Col. Hardgrove, with a station hospital, sees Maj. Robert Allison, Akron, rather often at medical meetings in London.

\* \* \*

Capt. Albert V. Black, Dayton, has been "roaming the continent of Europe with the 'movingest' station hospital in the Army". Accompanying him are the following Ohioans: Capt. Harold Bockoven, Verona; Capt. C. E. Clark, Dayton; Capt. E. W. Recroft, Cleveland; Capt. John F. Torrence, Germantown; and Capt. W. A. Reiling, Dayton.

\* \* \*

Capt. James R. Hart, Cleveland, is base surgeon at an A.T.C. Field near Oran, French Morocco, according to a news story. Overseas for 18 months, he was previously at Dakar, Senegal.

\* \* \*

More state-side station changes: Lt. A. J. Huesman, Cincinnati, Amphibious Training Base, Little Creek, Va.; Capt. Morris Hyman, Cincinnati, 1272 SCU, England General Hospital, Atlantic City, N.J.; Lt. (j.g.) Walter G. Hunsberger, Cincinnati, Naval Air Tech. Tr. Ct., Epidemiology Unit 43, Norman, Okla.; Comdr. Abe Cline, Dayton, Naval Hospital, U.S.N.A.S., Jacksonville, Fla.; Maj. H. L. Hauman, Toledo,

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\* \* \*

Navy Lt. Perry R. Ayres, Columbus, added to the glorious record of Ohio's medical men in the service by setting up the first beach evacuation station for wounded Marines on Iwo Jima. Dr. Ayres with a dentist and nine Navy corpsmen went ashore in an amphibian tractor five hours after H-hour on D-day, according to a news dispatch from a Marine Corps Combat Correspondent, Sgt. Jack Vincent, also of Columbus. The unit under constant mortar and artillery fire from the enemy during the first five days, worked around the clock 24 hours a day until they were given some relief on D-day-plus-five. After a short rest, they were back at their post. The news story quoted Dr. Ayres as stating that it was impossible to keep track of the number of wounded treated on D-day and night, but during the next four days the doctor and his crew evacuated more than 300 seriously wounded Marines, besides giving first aid treatment to a large number of less seriously wounded

\* \* \*

Capt. John J. Clark, Mansfield, is in the Philippines, the famous Hawkeye's photo organization of the Fifth Air Force. Overseas more than ten months, he also participated in the campaigns in New Guinea and the Netherlands East Indies. The Hawkeyes unit, of which Capt. Clark is flight surgeon, has been recommended for the Presidential Unit Citation for its excellent photo reconnaissance work in the Philippines.

\* \* \*

Correction—In the February issue of *The Journal*, it was reported that Dr. James J. Conn, Columbus, had been commissioned as Assistant

Surgeon, U. S. Public Health Service. This was an error. Dr. Conn has been commissioned, First Lieutenant, Medical Corps A. U. S., and is stationed at present at the Veteran's Facility Hospital, Bedford, Mass.

\* \* \*

Still with a station hospital serving an air base in North Africa, Capt. Isador Miller, Urbana, says his practice is very much like that in a civilian hospital, with many patients returning to the Z. of I. by air being "boarded" there. "Our war experiences are obtained vicariously from the transient patients", he comments.

\* \* \*

Maj. L. Burdett Wylie, Cleveland, V-mails a new A.P.O. from Paris. He is with a general hospital.

\* \* \*

At sea, aboard a transport, Lt. Harold C. Klein, with a medical attachment of an armored engineer outfit, sends his new A.P.O. so that he'll get *The Journal*, wherever he's going.

\* \* \*

Maj. J. K. Gibson, Tiltonville, has been doing considerable general surgery in a station hospital to which he has been attached in Africa and Italy for 18 months. Other Ohioans in the unit are: Maj. Gordon Nelson, Youngstown; Maj. J. J. DelVecchio, Yorkville; Capt. J. D. Knapp, Cambridge and Capt. Jack Engelman, Cleveland.

\* \* \*

Another Ohio doctor with the Armored Force is Capt. Carl J. Paternite, Toledo, in a tank battalion attached to the Third Army in Luxembourg when he wrote. He got there via England, France and Belgium, and no doubt is in another country by this time.

\* \* \*

Capt. Carl R. Damron, Mansfield, is making good use of his specialty, anesthesia, with an evacuation hospital in Holland.

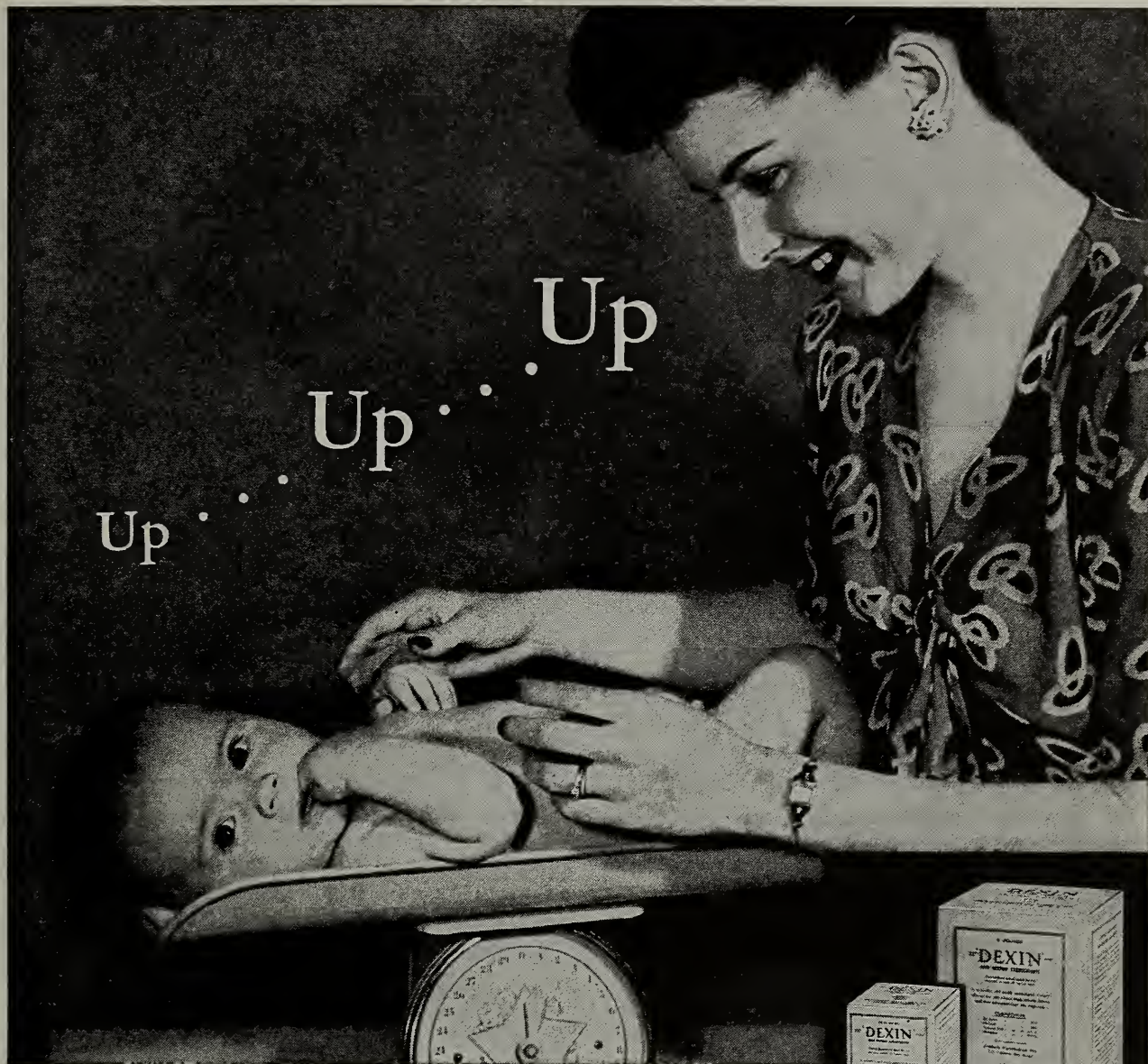
\* \* \*

"If you ever want to appreciate the State of Ohio, come and live in Arkansas", writes Capt. Robert R. Blondis, Shaker Heights, who is ophthalmologist at the Station Hospital, Pine Bluff Arsenal, Ark. Dr. Blondis has written several papers based on his work there on the effects of chemical warfare agents before they have been used in actual combat, among them one in the *Archives of Ophthalmology* in December, 1944, and in *The Military Surgery* for January, 1945.

\* \* \*

Lt. Col. Anthony Ruppertsberg, Jr., Columbus, recently returned from two and one-half years hospital duty in the Fijis Islands, has been assigned to the Office of the Surgeon General, Washington, D. C., in the Hospital Division, Operations Service.





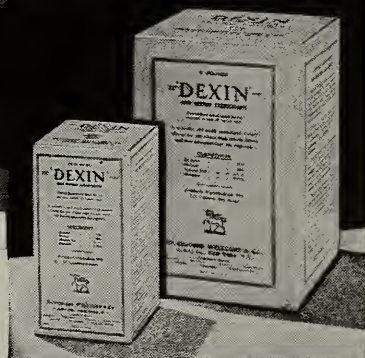
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# The Physician's Bookshelf

**Approved Laboratory Technic**, by John Kolmer, M. D., and Fred Boerner, M. D., (\$10.00. 4th Ed. *C. Appleton-Century Co., New York City*) is the current edition of a manual originally brought forward by The American Society of Clinical Pathologists to establish standards. Russell L. Haden and Harry L. Reinhart are the Ohio collaborators. The book remains as authorization on standard techniques.

**The 1944 Year Book of Dermatology and Syphilology** edited by Marion B. Sulzberger, M. D., and Rudolf L. Baer, M. D., (\$3.00 *The Year Book Publishers, Inc., Chicago*) maintains its previous standards in spite of the war. Many of us wait with interest for the opening chapter of this book. This year is devoted to skin tests.

**Microbiology and Pathology**, by Charles T. Carter, M.D., (\$3.50. 3rd Ed. *The C. V. Mosby Co., St. Louis*) is a revision of the well-known and successful text for nurses.

**The Neurologist's Point of View**, by I. S. Wechsler, M.D. (\$3.00. *L. B. Fisher Publ. Co., New York City*) is a collection of essays on psychiatric and other subjects. It is a book that all who are interested in the field will enjoy. All of us ought to read the book for unpatronizingly and simply this great man discusses the prejudices and conflicts that harm our lives as individuals and as world citizens. Much space is given to the difficulties of social adjustment. His best essays are on the psychological sources of anti-Semitism, the work and personality of Freud, the history of psychiatry and the nervousness of the Jew.

**Neuro-Ophthalmology**, by Donald J. Lyle, M.D., (\$10.50. *C. C. Thomas, Publisher, Springfield, Ill.*) is by one of Ohio's outstanding students of the eye. The book attempts to bring together in a brief but comprehensive and coordinated manner those many phases of neurology as they concern ophthalmology. The text is profusely illustrated. A bibliography of 1,718 references has been compiled from the literature of the past eight years and is appended to the text. The last has been done successfully and the book therefore belongs in the working library of every ophthalmologist, neurologist, neurosurgeon, and otolaryngologist.

**Trauma in Internal Diseases With Consideration of Experimental Pathology and Medico-legal Aspects**, by Rudolph A. Stern, M.D.; Foreward by Frances Carter Wood, M.D., (\$6.75. *Grune & Stratten, Inc., New York City*) presents in a brilliant discussion one of the most difficult fields in medicine, that of the relation of

trauma to internal diseases. The book fills a crying need and is of interest to every physician. It is equally vital to those whose work brings them in contact with accident cases and to those who undertake to give "expert" testimony in such cases.

**Medical Gynecology**, by James C. Janney, M.D., (\$5.00. *W. B. Saunders Co., Philadelphia*) has been developed from the author's experiences in clinical teaching at the Boston University School of Medicine. The scope is limited to office practice. It very successfully correlates the didactic lectures of the class room with the complaints of the woman in the examination room in terms of physiological pathology.

**Peripheral Nerve Injuries. Principles of Diagnosis**, by Webb Haymaker, M.D., and Barnes Woodhall, M.D., (\$4.50. *W. B. Saunders Co., Philadelphia*) is another army manual. It represents a collection of diagrams illustrating the anatomy and function of peripheral nerves and the methods of examination, all illustrated with the essential clinical data to make a most valuable book.

**The Surgeon's Hands and Other Poems**, by Ida Norton Munson, (\$2.00. *Bruce Humphries, Inc., Boston*) is a collection of poems which have appeared in important magazines. The little poem, "The Surgeon's Hands," hangs in many hospitals and surgeons' offices.

**Oriental Health Remedies**, by Paul M. Kourennoff, (\$2.00. *Published by the Author, Box 121, San Francisco*) presents an interesting collection of folk remedies.

**Microbial Antagonisms and Antibiotic Substances**, by Selman A. Waksman, (\$3.75. *The Commonwealth Fund, New York City*) is a timely volume summarizing the facts of this interesting subject. The discovery of antibiotic substances such as penicillin and tyrothricin make this a must book for all who wish to keep abreast of the fight against pathogenic bacteria.

**Essentials of Allergy**, by Leo H. Crip, M.D., (\$5.00. *J. B. Lippincott Co., Philadelphia*) is a well-planned presentation of the facts in this field. The author hews strictly to the line of facts as they are now interpreted. It is a sound and up-to-date book.

**The World Healer**, by Paul M. Kourennoff, (\$2.50. *Published by the Author, Box 121, San Francisco*) is a continuation of another volume, "Oriental Health Remedies". This work presents 23 more folk remedies and a novel of the future which gives the volume its name.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

May, 1945

No. 5

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## The Present Status of the Prostatic Problem\*

HERMAN L. KRETSCHMER, M.D.

IN a discussion of the present status of the prostatic problem it may not be amiss to briefly review this subject beginning just before the turn of the century. Dr. Belfield in 1887 published his paper on suprapubic prostatectomy and is credited as being the first American surgeon to have deliberately performed this operation for the removal of an obstructing middle lobe of the hypertrophied prostate. This was followed by the writings of McGill, of Leeds, in 1887 and 1888, on suprapubic prostatectomy. In 1891 Goodfellow was the first in this country to deliberately carry out perineal prostatectomy. Freyer claimed priority in performing total prostatectomy, as all previously reported operations were only partial prostatectomies.

These papers served to direct the treatment of prostatic obstruction along surgical lines. It should be borne in mind that there was no such program, as we know it today, of careful preoperative study. The roentgen ray had just been discovered and its use in the prostatic patient unknown; functional tests and their use in the prostatic patient was something for future development. The preoperative preparation of the patient was an unknown subject.

Needless to say the mortality was very high so that the patient was advised to use a catheter in lieu of operation. As a matter of fact a statement was made by a prominent physician at a medical meeting in Chicago that there was nothing to do for these old men, but to give them a catheter and let them go home and die.

### *The Author*

● Dr. Kretschmer, Chicago, Ill., is a graduate of Northwestern University Medical School, 1904; President, American Medical Association; ex-president, American Board of Urology, American Assn. of Genito-Urinary Surgeons, Clinical Society of Genito-Urinary Surgeons, American Urological Society; member, Western Surgical Assn., American Radium Society, Chicago Pathological Society, and Editorial Board, American Journal of Urology; urologist, Presbyterian Hospital, and consultant urologist, Children's Memorial Hospital; prof. of urology (Rush Medical College), Department of Surgery, University of Illinois.

From this point of view, dismal and dreary as it was, to the present optimistic point of view regarding our ability to cure the patient represents a great triumph in urology.

### HISTORICAL NOTES

The high plane of efficiency in the treatment of the prostatic patient did not "just happen". It is the result of a definite plan of preoperative study and preparation that was developed step by step during the past 20 or 25 years.

The importance of improving and stabilizing the renal function, the need for slow decompression in the patient with chronic distention of the bladder, the importance to clear up infection when present by indwelling urethral catheter or suprapubic cystostomy are milestones in the preoperative treatment. The use of anesthesia, other than ether; improvement in surgical technique, and the demand to control

\*The Lower Lecture delivered at the meeting of the Cleveland Academy of Medicine, November 24, 1944, held in Cleveland, Ohio.

bleeding during the operation all have helped to reduce operative mortality.

The urologist was the first to recognize the value of "pushing fluids" in these patients, long before this need to replace fluids in the dehydrated patient was generally recognized and used.

It is extremely interesting to recall the various discussions regarding the merits of the suprapubic versus the perineal operation, and the discussions among the perineal prostatectomists regarding the relative merits of one type of perineal operation over the other.

The attempt to remove prostatic obstruction without open operation is not new. More than 100 years ago Stafford, Guthrie, Leroy d'Etiolles and Mercier devised various instruments to relieve prostatic obstruction.

Bottini, Freudenberg, Chetwood and Wishard all devised methods to overcome obstruction. Young developed his cold punch for the treatment of median bars, which was later improved upon by Braasch and Bumpus. To Dr. John R. Caulk must be given credit for his persistence with his cautery punch in transurethral methods.

Great impetus was given to the transurethral treatment of prostatic obstruction by the perfection of the resectoscope through the efforts of Stern, McCarthy and Davis. This new procedure was the subject of much controversy, just like the aforementioned arguments between the suprapubic and perineal prostatectomists.

#### THE MODERN VIEW

Today a new line of discussion has made itself manifest. The adherents of surgical prostatectomy support their view with series of cases who had transurethral resections and because the patients were unrelieved of their symptoms, they were obliged to undergo surgical prostatectomies. From these publications one gains the impression that the operation is of but limited value and that the failures are very numerous.

The number of resections performed is very large and the number that require surgical prostatectomies is relatively small. In discussing this group of patients it should be remembered that many of the patients were operated upon in the early days of resection, at a time when the operator's skill and dexterity no doubt were not on as high a plane as today.

As I pointed out many years ago, the symptoms of prostatism may recur following suprapubic prostatectomy and in cases in which complete prostatectomy was performed. However, I pointed out that a long interval elapses between the prostatectomy and the recurrence of the symptoms.

Recently Emmett reported a large series of

cases in which prostatectomy was performed by competent operators and because of recurrence of symptoms or failure to obtain relief, transurethral resection was performed. Thus we now have the prostatectomists showing failures following resection and the need for prostatectomy, and we have the resectionists showing the failures of prostatectomy and the need for resection to cure the patient. No doubt as these discussions continue this problem will be still further clarified.

#### FAILURES

It is evident that failure to relieve a patient may follow any kind of surgical operation, and that no operation is 100 per cent successful in every patient. Our desire to obtain 100 per cent results in every patient has resulted in the splendid surgical results attained in every field of surgery.

The object of the treatment is the relief of obstruction. This is the prime consideration. The procedure to be used should be the one with the lowest mortality rate, the shortest period of morbidity, one with the least number of postoperative complications, and one which results in complete restitution of function.

#### THE SELECTION

The method to be used, it seems to me, depends entirely upon the urologist and his skill with one procedure or another. In my experience these criteria are best accomplished by transurethral resection. There seems to be general agreement among the urologists that the cases of contractures of the internal urethral orifice, median bars, small middle lobes, small lateral lobes and carcinoma are suitable for transurethral resection. The present discussion hinges around the management of the very large prostate and the very vascular prostate. Opinions still differ on the management of this group of cases.

I have never made any selection of cases and I have performed only three suprapubic prostatectomies during the past 14 months. The reason for operating upon these three patients was due to the fact that it was impossible for me to introduce the resectoscope because of the enormous size of the prostate gland. Increased vascularity leading to increased bleeding during the operation, while a troublesome problem, is not a contraindication for resection.

The large prostate, in my opinion, is no contraindication for resection. I frankly tell the patient that he has a large prostate and it may be necessary to perform two resections. I can see no objection to two resections. Let us not forget the large number of two-stage prostatectomies that were performed not so many years ago.

I am sure the urologists here tonight have



had the same experience I have had with the physician-patient. No matter how large his prostate may be he always insists on having a resection.

#### MORTALITY

There is no longer any question of the fact that resection carries the lowest mortality rate. Many large series of cases have been reported from all parts of the country with a mortality rate of from 1 to 3 per cent. A review of the last 600 transurethral resections I performed at the Presbyterian Hospital shows a mortality rate of 1.3 per cent.

Failure to relieve the patient of his symptoms may be due to many different reasons. Some may be due to incomplete removal of the obstruction. During the early days of resection, it was the vogue to make a wide channel. It was believed that this was all that was necessary. Gradually our attitude changed and it was urged that the more tissue removed the better; that we should attempt to do a complete transurethral prostatectomy. I believe this latter represents the view of the urologists of the country today. Interesting in this connection is the recent publication by Emmett who showed a definite increase in mortality depending upon the amount of tissue removed. Thus the mortality in the group in which small amounts of tissue were removed was 0.3 per cent, whereas in the more extensive resections the mortality was 1.1 per cent.

#### RECURRENCE

The recurrence of symptoms may be due to an overlooked carcinoma or carcinoma may develop subsequently as has happened in cases of open prostatectomy, a fact well known to all urologists.

In an occasional case the symptoms may be due to the development of a stone in the bladder. I have seen 3 cases in which an overlooked chip formed the nucleus of the stone.

Excessive scar formation, although rare, has been responsible for symptoms. Urethral stricture, while infrequent, does occur and at times may be most annoying.

The persistence of symptoms as well as pyuria and bacilluria, even after complete removal of the obstruction, may be due to the presence of a large hydroureters and hydronephrosis. In another group persistence of symptoms are due to too much indiscriminate and deep fulguration of bleeding points.

#### HEMORRHAGE

The importance of careful hemostasis during the resection needs no discussion. The principle of hemostasis applies as well in the field of resection as it does in any other type of sur-

gery. Elderly patients stand blood loss very poorly. It is so easy to overlook the fact that the patient may lose large amounts of blood during resection and often larger amounts than we think. We recently undertook to estimate the blood loss in a series of cases and I was greatly surprised to note that it was relatively large. Our figures show that in the first group the average blood loss was 281 cc.; in the second group 109 cc.; in the third group 62 cc.; and in the fourth group 64 cc. In other words, as we become more and more meticulous in the control of bleeding the amount of blood loss becomes less and less. We try to send the patient back to his bed with the wash-water clear.

The place to stop the bleeding is in the operating room. One must visualize the bleeding point and apply the current to it directly rather than to fulgurate more or less deeply and indiscriminately. As a rule, hemostatic bags do not have to be used. Even after the bleeding has been controlled there is a certain amount of oozing after the patient returns to his bed in some instances. In cases in which it is evident that the patient has lost an excessive amount of blood, a transfusion is given before he leaves the operating room. There is no question that careful hemostasis has been a big factor in reducing the operative mortality.

#### STONE IN THE BLADDER

A certain number of cases are associated with stone in the bladder. Their management causes no special problem. If the stone is small and the infection mild, the stone is crushed and fragments evacuated at the time of the resection. If the stone is large and the infection severe, a suprapubic cystostomy is done. The resection is carried out later. The presence of the suprapubic opening is no contraindication to resection. If the patient has a severely infected bladder, a suprapubic cystostomy is done. However, each year the number of them diminishes.

The patient with chronic urinary retention should have the benefit of slow or gradual decompression. Resection is never an emergency operation. During the period of decompression one has ample opportunity for careful detailed study of the patient and for suitable preoperative preparation.

The management of the patient with residual urine has undergone some changes. Whether or not one should drain with an indwelling catheter depends on one's personal point of view. If the general condition of the patient is good, the renal function satisfactory, and not much infection is present, even if the

amount of residual urine is 8 ozs., I no longer institute preliminary catheter drainage.

Likewise our point of view on what constitutes the upper limit of retention of non-protein nitrogen has changed in regard to operability, so that relief of obstruction is granted to a much larger group of patients with impaired renal function than was the case in the early days of resection.

Some difference of opinion still exists regarding vasectomy. Vasectomy is a routine procedure among some of the urologists. The incidence of epididymitis is so infrequent in my hands that I do not believe that I am justified in performing routine vasectomies.

It is a well known surgical fact that surgical mortality increases with each decade, yet many men between 80-90 and 90-100 have been operated upon successfully in large numbers with a much lower mortality than the patients who formerly were subjected to surgical prostatectomy.

There seems to be a tendency on the part of some urologists to perform what they designate as "prophylactic resection". Given a patient with a certain amount of enlargement of the prostate and with a few urinary symptoms, a small amount of residual urine, they recommend carrying out a resection on the theory that this will prevent enlargement. I can not subscribe to this point of view and have never performed the so-called prophylactic prostatectomy. In view of the fact that many of these patients carry on for many years without an increase in their symptoms and often die of an intercurrent disease, I believe that when a patient is to have a resection he must have definite symptoms and conditions that justify a resection.

#### CANCER

Interest in the treatment of carcinoma has recently been aroused by the use of orchiectomy and stilbesterol. Briefly, the present point of view in the treatment of carcinoma may be discussed under three headings:

1. Those who believe that all patients should be subjected to extensive radical perineal operations. The champions of this form of treatment are Young and Smith of Boston. Unfortunately, so many patients with carcinoma of the prostate come in when the cancer is well advanced and has spread beyond the confines of the prostate. Then too in some of the early cases metastases are present. You probably are all familiar with the patient who has a pathological fracture and the primary focus after careful search is located in the prostate and may not be larger than a pea. You must also remember that carcinoma extends along the perineural sheaths so that even if it ap-

pears that the carcinoma is limited to the prostate, it may have spread via this route.

2. Those who before the wave of endocrine therapy were content to treat the patient with transurethral resection to relieve obstruction and to repeat this whenever obstruction recurred.

3. Those who believe that carcinoma of the prostate is amenable to endocrine therapy and orchiectomy. When this treatment was first advised, it was received with great enthusiasm. It was hoped that this would cure the patient. Unfortunately, my experience has been disappointing, as has been the experience of others who reported their follow-up results. In some cases, the results appear remarkable for the time being.

#### STILBESTROL

The use of stilbesterol has many adherents and promises to be of value. Unfortunately, the time that has elapsed since the introduction of this agent is too short to allow one to make a statement that it does cure cancer. Undoubtedly in some cases it does seem to influence the size and consistency of the prostate. In others there seems to be no response to its use.

#### SELECTION OF CASES

No one can deny the statement that resection has made it possible for a large group of patients to obtain relief of their urinary difficulty who for one reason or another could not be successfully operated upon by open surgery. The fact that this group of patients can be relieved is one of the outstanding advantages of this operation.

Many patients with cardiovascular lesions have been told that open surgery was out of the question. The man who has had one or more attacks of coronary thrombosis, the patient with hypertension, the cardiac with attacks of angina, are sent in by their physicians with the specific request that a resection and not a prostatectomy be done.

It is interesting to reflect that in the days of open surgery 35.4 per cent of the patients upon whom I did a suprapubic prostatectomy had cardiovascular diseases. A recent study showed that 65 per cent of patients who had a transurethral resection had cardiovascular disease. This again shows the ever widening field of usefulness of resection.

Patients with extensive carcinomatosis, hemiplegia, ascites, advanced tabes dorsalis and other serious diseases, who would ordinarily be doomed to catheter life or a suprapubic catheter with its inherent difficulties can easily be relieved with resection.

As is well recognized, the number of days of hospitalization in the prostatic patient has



been very materially reduced. In my experience the patients who have had a resection remain in the hospital about a week. This is to be contrasted with the patient who stayed in the hospital six to eight weeks following suprapubic prostatectomy. The importance of this is very apparent to every one at the present time when all of our hospitals are full to capacity and a faster turnover of patients is desirable.

These patients no longer have the dread that was manifested by the patients with prostatic obstruction in the days of open surgery. They realize that their obstruction may be relieved by a method that does not call for long hospitalization, high mortality and serious complications. For this reason the patients seek relief at a much earlier period than they did 20 years ago. The advantages of early treatment need no remarks. As a result of seeking earlier relief, we no longer see many of the pathological conditions that were once so common. I am sure most of the urologists will be in accord with the statement that he no longer sees so many patients with hydronephrosis, large bladder stones, large diverticula, and many other old pathological conditions.

The achievements of urology in this branch of surgery is one of which we may justly be very proud and one which meets some of the charges made that the profession is doing nothing about the diseases of old age. I believe that urologists are in the forefront of relieving this group of old-age patients.

I would like to call your attention to another problem that has been created by resection and its low mortality rate. These are elderly people and in this day and age of intensive industrial work they find it difficult to obtain employment because they no longer can compete with the younger men in industry. This naturally leads to the social problem of an increasing number of unemployables. This subject has received the earnest, serious consideration of all of the doctors in this country. And then too this ever increasing number of elderly people will be further subjects of other degenerative diseases.

The recent literature contains many reports concerning the effectiveness of thiouracil in the treatment of hyperthyroidism in adults. This drug has been used in approximately 2,000 cases up to the present time in this country, and there is uniform agreement upon its beneficial influence in thyrotoxicosis.—Frederic Gerard Burke, M.D., Washington, D.C.; Med. Annals of D.C., Vol. XIV, No. 3, March, 1945.

## KEEPING UP WITH MEDICINE

THE medical profession can not provide health. Health comes from good food, adequate shelter, sanitation, hygiene, and moderation in all things. None of these can we supply.

\* \* \*

GIVEN a patient with chronic indigestion, or dyspepsia, it is wise to remember that there is no such disease. The condition is often reflex in nature and the chief sites of the organic diseases initiating this trouble are the gallbladder, stomach, appendix, and large bowel, including the rectum.

\* \* \*

IN any diarrheal condition, in a patient who has seen service abroad, we must keep in mind the possibility of amoebiasis. Bacillary dysentery, especially in the chronic form, and Giardial and balantidial infection must likewise be excluded.

\* \* \*

ALTHOUGH we should not make the mistake of exaggerating the frequency or importance of vitamin deficiencies, it is still our duty to see that even minor injuries due to deficiencies be prevented and cured by proper measures.

\* \* \*

WHAT is meant by a trace mineral is illustrated in the life of the sheep. One-tenth of a milligram used in the critical case makes the difference between life and death in the sheep.

\* \* \*

COMMON salt is not needed in the amounts consumed by most of our people.

\* \* \*

ON last analysis, it is the severity and the localization of organic arterial disease, other than the blood pressure per se, which points to the prognosis.

\* \* \*

IF one is infected by a mosquito with *Wuchereria bancrofti* which injects a certain definite number of microfilaria, it is impossible ever to have more than *that* number of adult worms in one's body regardless of how long one lives. In other words, the adult worms are not able to reproduce themselves in the human body.

\* \* \*

THE treatment of kidney disease and hypertension with the Rice Diet by Walter Kempner, M.D., at Duke University is attracting a great deal of attention. He tries to compensate renal metabolic dysfunction by replacing the ordinary mixed diet with a diet limited to rice, sugar, fruit, and fruit juices, supplemented with vitamins and iron.

—J.F.

# A Case of Osteomyelitis Treated With Penicillin With Unusual Bacteriologic Findings

WM. G. MYERS, M.D., and FLORENCE LENAHA, M.D.

**Case History:** White male, 11 years old, admitted to University Hospital February 21, 1944, for treatment with penicillin of an acute exacerbation of a chronic osteomyelitis of the right femur and ilium. Thirty months previously a pustule, which had formed over the right knee cap following an injury, was opened by a parent. Pain in the right hip and thigh accompanied by chills and fever followed in two days. Three weeks later the thigh became tender, hot, red, and swollen, and X-ray revealed osteomyelitis of the proximal end of the right femur. Treatment with sulfonamides and blood transfusions were unsatisfactory.

Thereafter, followed the typical story of chronic osteomyelitis: Repeated episodes of chills and fever accompanied by intense pain; marked prostration, anorexia and failure to gain weight or to respond to transfusions, sulfonamides, or prolonged courses of staphylococcus toxoid. About six months after the start of the disease, there appeared four draining sinuses on the lateral and medial aspects of the right thigh, and two of these were still draining at the time of admission.

The right ileum had been operated twice before we saw the patient eighteen months before admission. At that time, a cast about the waist, encasing the right hip and thigh, and extending to the knee, was applied and changed seven times prior to admission. This management resulted in a decreased frequency of the exacerbations; the appetite improved, and the patient began to gain weight. A year before admission pain over the right mastoid process developed, followed by otitis media and a purulent discharge. Repeated courses of sulfathiazole insufflations resulted in improvement over a period of several months but then became ineffective.

Seven days before admission, the patient fell at school. Intense pain in the right thigh developed immediately, and his temperature rose to 103.4. Bed rest and codeine for the pain were prescribed. The next day the temperature of 104.6 was accompanied by chills, fever, profuse diaphoresis, and prostration. The right thigh became swollen beneath the cast. During the next few days while penicillin was released by Chester S. Keefer, M.D., and received to treat this case, sulfathiazole was again resorted to, and the temperature gradually fell to 100.0 when admitted to the hospital.

At that time, blood culture revealed hemolytic *Staphylococcus aureus*, coagulate positive. The blood count was 4.66 million erythrocytes and 31,000 white cells. Differential by C. A. Doan, M.D., and his staff by the supravital technique: 75 per cent neutrophils, 2 per cent basophils, 16 per cent lymphocytes, and 7 per cent monocytes. The hemoglobin was 9.8 grams, the cell volume 35 per cent, and the corrected sedimentation rate 1.5 mm. per minute.

Submitted March 18, 1945.

## The Authors

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● Dr. Lenahan (Myers), Columbus, Ohio, is a graduate of Ohio State University College of Medicine, Columbus, 1940; and assistant in Dept. of Medicine, Ohio State University College of Medicine.

The cast was removed and roentgenograms revealed rarefaction of the right ilium and femur typical of chronic osteomyelitis lesions.

Seventy-five hundred units (4.5 mg.)\* of penicillin sodium were injected intramuscularly every three hours (60,000 units, or 36 mg. per day) for the next 4 days. Because of the limited supply, the dosage was reduced to 5,000 units (3.0 mg.) every 4 hours (30,000 units, or 18.0 mg. per day) for the next 7 days. No penicillin was available for 2 days. Dosage was then resumed at 7,500 units (4.5 mg.) every 3 hours for 3 days, when it was changed to 7,500 units every 4 hours (45,000 units, or 27.0 mg. per day) until a total of 1,000,000 units (0.6 gm.) had been administered 23 days in the hospital. After each intramuscular injection, the needle was changed, 1 ml. of sterile distilled water was drawn into the syringe, and the resulting dilute solution of penicillin was injected deep into the draining sinuses. This procedure was adopted for local administration to conserve the drug; assay revealed that solutions thus prepared contained approximately 200-400 units per ml.

\*The International Unit of Penicillin has been defined recently<sup>7</sup> by the International Conference on Penicillin as "the specific penicillin activity contained in 0.6 microgram of the International Penicillin Standard." This Standard consists of a specimen of the pure crystalline sodium salt of Penicillin II or G. Since there are many advantages to expressing quantities of drugs on a weight rather than a unit basis, and 3.0 mg. is the equivalent of 5,000 Oxford or Florey units by the above definition, the weight in terms of the activity of the pure crystalline sodium salt of Penicillin II or G will be enclosed in parentheses following each expression of quantity in terms of units throughout this communication. It seems to us that this alternative method is more desirable in view of the highly refined preparations of penicillin (as high as 800-1100 units per mg. or 48-66 per cent active principle) currently being distributed by many of the producers.<sup>8</sup> The situation is somewhat analogous to the practice of evaluating some commonly used crude or semi-refined drugs, such as cinchona bark, belladonna, digitalis, etc., in terms of the content of the active principle. We submit that the method proposed for evaluating penicillin is superior to employing the terms "packages" or "vials" (containing 60 mg. or 100,000 units each) alternately with "units" as is coming into usage in some places.<sup>8</sup> The latter method is mentioned only to condemn it.



On the 6th hospital day, the temperature spiked to 102.6, and the next day vesicles typical of chicken-pox appeared on the hands, face, and trunk. He was moved to the isolation ward. At this time, the total white count was 8,400 with 64 per cent neutrophils; erythrocytes, 3.97 million; hemoglobin, 9.8 grams. Three days after the vesicles appeared, the total white count was 12,000; the supravital differential had shifted to 28 per cent neutrophils, 59 per cent lymphocytes (30 per cent small, 25 per cent intermediate, 4 per cent large), and 13 per cent monocytes.

On the 10th day of treatment, one of the two draining sinuses on the thigh ceased to discharge pus and healed over. Five days later, the boy volunteered that his thigh did not feel numb nor ache for the first time since the start of his disease. About this time drainage from the right ear stopped. The corrected sedimentation rate had fallen to 0.9 mm. per minute.

Cup-plate assays by the method of Abraham et al.,<sup>1</sup> were run on 24-hour refrigerated urine specimens. The concentration of penicillin per ml. of urine varied between 9 and 38 units, depending somewhat on the total volume excreted. The per cent of the total dose of penicillin injected which appeared in the urine each day varied between 22 and 84; the average for 15 24-hour specimens was 48 per cent. Refrigerated 12-hour specimens were assayed beginning after the last dose of 7,500 units had been injected intramuscularly. The first of these specimens contained 6.5 units per ml.; the second, 2.6 units; and the third, no penicillin.

At the time of discharge from University Hospital, the patient was improved subjectively, and his temperature and white cell count were normal. His sedimentation rate had decreased greatly, but the anemia showed little improvement. Drainage from his ear and one of the sinuses on his leg had stopped; drainage from the other sinus had diminished sharply. The unilateral hip spica was again applied. Two weeks later drainage from the remaining sinus became more profuse. One month later the purulent material contained no staphylococci. Three months after the discharge from the hospital staphylococci still could not be cultured from the pus.

On July 10, 1944, the patient was admitted to White Cross Hospital complaining of severe abdominal pain and with marked tenderness in the right lower quadrant. The temperature was 104.0. Appendicitis was suspected, but subsequent events indicated that another abscess of the ilium had formed which eventually broke into and drained from the sinus already present. Hot magnesium sulfate compresses were applied.

Since the drug had become more readily available, a second and more intensive course of penicillin was decided upon at this time. Accordingly, 30,000 units (18.0 mg.) in distilled water were injected intramuscularly every three hours beginning July 11 and continuing to July 17 when the dosage was reduced to 30,000 units every four hours and continued at this level until July 22. A total of 2,500,000 units (1.5 gms.) were injected during 11 days.

On July 11, 1944, the white blood cell count was 15,700 with 75 per cent neutrophils and 25 per cent lymphocytes. Hemoglobin was 80 per cent and erythrocytes 4.2 million. On July 21, 1944, the blood picture had altered very slightly to 14,400 leucocytes; 63 per cent neutrophils, 35 per cent lymphocytes, and 2 per cent

eosinophils. Pure cultures of *Staphylococcus albus* were obtained from the draining sinus on July 14, July 16, and July 19, 1944, by the hospital laboratory. The temperature spiked to 103.6-104.4 during each of the first 4 days, after which it gradually fell to and remained normal at the end of the first week. He was discharged July 24, 1944, after again applying the unilateral spica cast.

Ten days later a culture of *Staphylococcus aureus* on nutrient agar slants was obtained from the draining sinus in our laboratory. When this strain of the organism was plated out in the cup-assay method, the colonies were albus in character, and no zones of inhibition appeared around the cups even when they were filled with 10 units of penicillin per ml. Under identical conditions, the controls with the standard 209 strain of *Staphylococcus aureus* gave inhibition zones 25-27 mm. in diameter when the cups contained only one unit of penicillin per ml. Since that time, the original nutrient agar slant cultures have been kept at 3-5°C.

Recent attempts to confirm the above apparent fastness to penicillin of this strain by the cup-assay method revealed the organism again to have the pigment of *Staphylococcus aureus* and that its inhibition by penicillin was comparable to the standard 209 strain, viz., zones of inhibition approximately 25 mm. in diameter with one unit of penicillin per ml. in the cup.\*\*

When the patient was again seen at the office on September 29, 1944, a remarkable improvement was noted. He had gained nine pounds, the draining sinus had spontaneously closed about three weeks previously, and roentgenograms revealed an appreciable increase in density in the rarefied areas seen on the films exposed on February 21, 1944. The cast was removed, and the patient has continued to gain weight and to improve generally with no indication of further abscess formation.

#### DISCUSSION

Because of the chronicity of osteomyelitis, recovery in this case may be apparent only, and due instead to a spontaneous remission. However, this seems unlikely in that there has been no fever or pain or other evidence of the disease in more than seven months; the patient has gained weight and otherwise improved steadily during this time; and roentgenograms indicate that bone healing is taking place.

The question then arises as to whether the penicillin was contributory to the recovery in view of the demonstrated complete fastness of the organism recovered from the draining sinus after the second course of penicillin. That it was seems probable to us because the patient received no specific treatment other than penicillin, and spontaneous recoveries of untreated cases of chronic osteomyelitis are uncommon.<sup>2</sup>

The sulfathiazole administered just prior to hospitalization the first time was probably ineffective (other than the obvious antipyretic effect) because it had been given in large amounts several times previously with little or

\*\*We are grateful to Marguerite M. Sullivan for these determinations.



no improvement, and the infective organism had undoubtedly become fast to it. Further, the admission blood culture was positive in spite of it.

Additional evidence that the penicillin may have been contributory to the improvement noted in this case is furnished by Kempf and Herrick<sup>2</sup> who studied the effect of penicillin on experimental *Staphylococcus aureus* osteomyelitis in rats. Twelve of the 27 animals treated with penicillin apparently recovered, whereas only one of 25 untreated controls showed evidence of recovery.

Unfortunately, cultures of the organism were not tested for natural penicillin resistance before the drug was started. That such a strain was responsible for the infection seems improbable in view of a recent report by Cooke<sup>3</sup> who found that 25 to 28 strains of *Staphylococcus aureus* isolated from various human sources were sensitive to 0.1 unit or less of penicillin *in vitro*.

We believe that the resistant strain in this case may have developed either because of inadequate dosage during administration of the first course of the drug, or because of the inability to obtain and maintain bactericidal concentrations at the sites of infection due to poor blood supply or necrotic pockets into which the penicillin did not diffuse well. Florey and Florey<sup>4</sup> and Rammelkamp and Maxon<sup>5</sup> report a similar development of resistant strains during the course of prolonged or repeated penicillin therapy.

Among several cases reported by Spink, et al.,<sup>6</sup> one of the strains they studied had several bacteriological features in common with that recovered in the present case. It was a *Staphylococcus aureus* isolated from the blood of a child, and it was inhibited initially by 0.04 unit of penicillin *in vitro*. After two courses of penicillin (2,000,000 units total given in the second course) between which there developed an osteomyelitis of a femur, there was isolated a strain of the organism from the osteomyelitic sinus which required 0.8 unit of penicillin for inhibition of growth.

In two of the four other strains of *Staphylococcus aureus* studied in which a 100-fold decrease in sensitivity to penicillin was induced by repeated transfers in media containing increasing concentrations of the drug, it was noted that the adapted strains produced much less pigment than the parent strains. This is in agreement with the hospital laboratory reports of *Staphylococcus albus* recovered from the draining sinus of the present case during the second course of penicillin, whereas the initial reports at the start of the first course of the drug were *Staphylococcus aureus*.

McKee and Houck<sup>9</sup> were able to develop a 6,000-fold decrease in sensitivity to penicillin

in a strain of *Staphylococcus* after 60 passages in cultures containing increasing concentrations of the drug. During this development of fastness, there was associated a loss in virulence for mice.

This interesting finding furnishes a possible explanation for the improvement in the present case. It is thought that during the development of the fastness of the strain to penicillin, there occurred an associated loss in virulence with the result that infection was finally overcome by the normal leucocytic and humoral mechanisms. Support for this view is furnished by Spink, et al.,<sup>6</sup> who found that four induced penicillin-resistant strains of *Staphylococcus aureus* were much more susceptible to the antibacterial action of human blood than the penicillin-sensitive parent strains.

The reversion of the penicillin-resistant strain to a penicillin-sensitive strain after storage for several months on a nutrient agar slant at 3-5°C. differs from the findings of Spink, et al.,<sup>6</sup> who reported that two induced penicillin-resistant strains of *Staphylococcus aureus* retained their lack of sensitivity after storage in a refrigerator for 3 months.

Todd, et al.,<sup>10</sup> found a rapid fall in resistance to penicillin after repeated subcultures in nutrient broth of two induced penicillin-resistant strains of *Staphylococcus aureus*. In experiments carried out similarly, Rake, et al.,<sup>11</sup> reported that Type III pneumococcus retained its induced penicillin resistance. Schmidt and Sesler<sup>12</sup> passed pneumococci through mice treated with penicillin until strains resistant to the drug were induced and found that this resistance was not lost by passage through 30 normal mice.

Obviously, there is a marked difference in the retention of penicillin-resistance by different species of bacteria, as well as by different strains of the same species. Youmans, et al.,<sup>13</sup> report the production of small colony variants of *Staphylococcus aureus* in concentrations of penicillin which markedly inhibited but did not completely stop growth. These forms underwent rapid reversion and probably were more penicillin-resistant than the normal. Such forms may account for the isolation of a penicillin-fast strain in the present case which may have been a small colony variant that later reverted when stored in the cold.

#### SUMMARY

1. Recovery followed the intramuscular administration of two courses of 1,000,000 units (0.6 gm.) and 2,500,000 units (1.5 gm.) of penicillin five months apart in a case of osteomyelitis of a femur and ilium of 30 months' duration together with a chronic otitis media in an 11-year old boy.

2. Repeated prolonged heavy courses of sul-



fathiazole administered previously had been ineffective.

3. Cultures of staphylococci recovered from a draining sinus immediately following the second course of penicillin were fast to penicillin *in vitro*. Recovery in spite of the development of this fastness to the drug is attributed to an associated concomitant loss either of virulence of the organism or of insusceptibility to the antibacterial action of blood or both.

4. The fastness of the organism to penicillin largely disappeared after several months of storage at 3-5°C.

5. During the first course of penicillin chickenpox appeared on the sixth hospital day in spite of the drug. This is another instance of the ineffectiveness of penicillin in many virus infections.

6. An average of 48 per cent of the daily dose appeared in the urine; the range was 22-84 per cent. The concentration varied between 9 and 38 units per ml. of urine, depending somewhat on the volume excreted. Penicillin had ceased to appear in the urine within 24 hours after the last intramuscular dose.

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The most accurate method of making the diagnosis of carcinoma of the large bowel is by X-ray through utilization of barium enemas. The barium enema is such a simple procedure that it should be done in all suspicious cases. However, it is unsound medicine to perform a complete gastrointestinal series when a carcinoma of the large bowel is suspected since obstruction is so common in carcinoma of the colon.—Warren H. Cole, M.D., Chicago; *Rocky Mtn. Med. Jr.*, Vol. 42, No. 3, March, 1945.

### The Pathologic Basis for The Clinical Manifestations in Nephritis

1. Each kidney is composed of approximately one million units, each unit essentially complete in itself, with its characteristic anatomic structure, its functions and its own blood supply. The different parts of each unit probably perform the following functions. The glomeruli furnish a filtrate consisting of a solution not only of waste products but all the crystalloidal substances in the plasma. The proximal convoluted tubules, by selective reabsorption, return to the blood substances which the body can ill afford to lose. Henle's loop reabsorbs water and concentrates the urine. The distal convoluted tubules alter the reaction of the urine and thus conserve alkali reserve and maintain the acid-base balance of the body. The parts of each unit are interrelated through their common blood supply which consists of two systems of capillaries—the glomerular and the peritubular. Interference with the blood supply of the glomeruli will also affect that of the tubules. Hence in disease of the kidneys the unit suffers as a whole.

2. The two chief types of non-suppurative renal disease are (a) glomerulonephritis (Bright's disease) and (b) vascular nephropathy. Although these two types differ markedly in their basic pathology, both interfere with the circulation through the kidneys. Vascular nephropathy is associated with hypertension and death usually results from congestive heart failure or from cerebral hemorrhage. Glomerulonephritis, because the changes in the glomeruli reduce filtration, usually ends in uremia. But occasional patients with vascular nephropathy die from renal insufficiency, while those with glomerulonephritis sometimes succumb to congestive heart failure. The six cases reported above illustrate the mechanisms by which either type of disease may run an atypical course with the clinical manifestations of the other.

3. In the early stages of glomerulonephritis, the inflammatory reactions in the glomeruli may be either exudative or proliferative in character. The exudative form, because of free drainage through the tubules, usually heals without serious consequences. The proliferative lesion, unless from some unknown reason the process ends spontaneously, progresses to a fatal termination.—James P. Simonds, M.D., Chicago; *The Illinois Med. Jr.*, Vol. 87, No. 3, March, 1945.

# Penicillin Therapy of Gonorrhea

HERBERT E. CHRISTMAN, M.D.

PENICILLIN has been available for treatment of sulfonamide-resistant gonorrhea at this Marine Corps Air Station\* during the past 7 months. Since our rate of sulfonamide cures had progressively diminished to slightly less than 50 per cent,<sup>1</sup> where it has since remained approximately constant, the addition of penicillin to our armamentarium was especially welcome. Thus far we have had no failures with this newest panacea, although our success with a single course of 100,000 units has been slightly less than in several series reported.

Our material comprises 130 cases of apparently uncomplicated acute anterior gonorrheal urethritis in the male, 22 cases of prostatitis, mostly chronic, 3 cases of epididymitis, and one case of gonorrheal ophthalmia. We have encountered no gonorrheal arthritis or gonococcemia.

## DOSAGE

In accordance with the recommendation of the Bureau of Medicine and Surgery of the U. S. Navy, our routine treatment has consisted of 20,000 units intramuscularly every 3 hours for 5 doses. Where a larger total dosage has been given, the individual dose, interval, and route have remained the same; the only variable has been the number of injections. Solutions have been freshly prepared daily from the sodium salt and distilled water, and kept refrigerated; refrigerator temperatures have been repeatedly checked and always found lower than 10°C.

There appears to be good reason for selecting the intramuscular route and the above dosage as a routine. Penicillin is too rapidly excreted when administered by intermittent intravenous injection, and there is some risk of thrombophlebitis at the injection site.

Although Herrell<sup>2</sup> reported all of 16 cases cured by 65,000 to 150,000 units given by continuous intravenous drip over a period of 48-72 hours, this method is necessarily somewhat confining and requires more nursing care; the results are not essentially different from those reported with comparable dosage given intramuscularly.

Sternberg and Turner<sup>3</sup> in an analysis of 1,686 cases from 15 Army hospitals, felt that results were better with the intramuscular route. In their series 50,000 units cured 86 per cent, 80,000-120,000 units 96 per cent, and 160,000 units 98 per cent. There was no difference whether treat-

## The Author

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ment was given in 10,000 or 20,000 unit doses. Menville and Ross<sup>4</sup> found only 40 out of 64 cured with 50,000 units (10 of the failures had complications), 25 of 29 cured with 100,000 units, 8 of 10 cured with 160,000-170,000 units, and 3 of 4 cured with 200,000 units. Robinson<sup>5</sup> reported 93 of 95 cured with one course of 100,000 units; one of the two failures was cured with an additional 100,000 units. Cohn et al.,<sup>6</sup> reported all of 23 women cured with 100,000 units, one failure with 50,000 units. Mahoney et al.,<sup>7</sup> reported 74 of 75 cured with 160,000 units, given in 16 injections. Ferguson and Buchholtz<sup>8</sup> obtained good results with various dosage schedules, but 100 per cent cures for all plans employing at least 100,000 units given in at least 5 injections.

All of the above reports except Herrell's<sup>2</sup> were based on the intramuscular route.

In brief, these studies indicate a definite superiority of 100,000 over 50,000 units but little if any advantage in the routine use of doses larger than 100,000 units.

## CRITERIA OF DIAGNOSIS AND CURE

Diagnosis in most cases has been made by direct examination of the Gram-stained urethral smear (also a conjunctival smear in one case). In all cases of prostatitis a positive culture of expressed prostatic fluid was obtained on chocolate agar plates. When a urethral discharge was present in cases of suspected prostatic involvement, the patient first stripped the urethra thoroughly and discarded the discharge, then voided, after which the prostatic fluid expressed by massage, invariably purulent, was cultured.

Prior to release from the sick-bay patients were required to have negative smears on four consecutive mornings; the discharge must either have entirely disappeared or be no more than a slight mucoid drop on stripping, showing few leukocytes and no diplococci; and the urine had to be absolutely clear in the second glass and contain no more than an occasional small shred in the first. If any Gram-negative diplococci were seen, either intra- or extra-cellular, more

The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large. Submitted November, 1944.

\*Cherry Point, N.C.



than 48 hours after treatment, the patient was retreated. Prostatic fluid cultures were not made routinely; one or more were made 48 hours or more after completion of treatment in all cases of prostatitis and in instances where discharge retained a purulent character, even though no gonococci were demonstrated on smear.

All patients were further observed at weekly intervals for several weeks after dismissal from the sick-bay before being finally discharged.

#### ANTERIOR URETHRITIS

Of 130 cases of uncomplicated acute anterior urethritis, 121 (93 per cent) were cured by 100,000 units. In many cases the discharge stopped after the second injection, and frequently no further discharge could be obtained for examination. Not infrequently, however, the discharge diminished promptly, lost its purulent character after 24 hours, but remained as a light mucoid drop for several days or more. This discharge showed no organisms, few leukocytes, and cleared up without further therapy.

Of the 9 failures with the original course of 100,000 units, 6 were evident within 5 days. The other three were diagnosed as failures 5 weeks, 6 weeks, and 8 weeks respectively after treatment. In each instance a slight discharge had been precipitated by excessive alcohol at an earlier date; the first two of the patients had not seen fit to report this, and the third had had repeated examinations without finding the organism. No complicating foci were found. We have no proof other than the patients' word that there had been no fresh exposure.

Four of the failures were retreated and cured with an additional 100,000 units; the other five required an additional 200,000.

The question arises as to whether a preliminary course of sulfonamide enhances the value of penicillin. It is theoretically conceivable that a strain resistant to penicillin might be susceptible to sulfathiazole and vice versa; it is also conceivable that a course of sulfathiazole inadequate to cure a relatively resistant strain might nevertheless lessen the virulence of the gonococcus and make it more susceptible to the action of penicillin. Twenty-two of our cases had had no previous sulfonamide or had received an inadequate amount to constitute a fair trial. They were all cured by 100,000 units. Nine failures occurred among the 108 who had previously received from 30 to 90 Gms. of sulfathiazole and/or sulfadiazine.

Oard et al.,<sup>9</sup> in discussing their treatment of gonorrheal urethritis, concluded that "the concomitant use of moderate amounts of sulfonamides (12 Gms.) and of penicillin (50,000 units) is strikingly more effective than when either drug is used alone". Rammelkamp and Keefer<sup>10</sup> had previously reported that a sub-effective amount of penicillin enhances the bacteriostatic effect of

sulfathiazole against staphylococcus aureus in whole defibrinated blood. On the other hand, Cohn and Seijo<sup>11</sup> found that sulfonamide-resistant strains of gonococci were not affected *in vitro* by sub-therapeutic doses of penicillin and sulfathiazole, and that sulfonamide-susceptible strains were inhibited more than sulfonamide-resistant strains by penicillin.

Since penicillin is usually packaged in 100,000 unit ampules, and since it is now readily available and not too expensive, we did not attempt to treat any cases with as little as 50,000 units. However, we did not find any advantage in combining sulfathiazole with 100,000 units. Of 19 patients so treated, 17 (89 per cent) were cured; of 111 patients treated with 100,000 units of penicillin alone, 104 (94 per cent) were cured.

#### COMPLICATIONS

Twenty-two cases of gonorrheal prostatitis occurred in our series. Seven of these were cured by 100,000 units, 7 by 200,000, 3 by 300,000, 2 by 1,000,000, and one each by 400,000, 600,000, and 3,775,000. In reviewing our data, we find no means of predicting which cases might require the larger doses. There is nothing distinctive about the "feel" of the prostate, symptoms, or character of the discharge in any of these cases. It might be supposed that early treatment would make for economy in dosage; yet one case probably 7 years' old required only 100,000 units, while another required 1 million. One case 9 months old required 100,000 units, another 1 million. Prostatitis complicating recent infections required from 100,000 to 600,000 units. Here again we could not detect a significant difference whether or not sulfathiazole was given with penicillin. All patients with chronic prostatitis received massages two or three times a week.

Two patients with unilateral epididymitis were promptly cured by 100,000 units; they had previously been unaffected by prolonged sulfathiazole administration and bed rest. One had also had three bouts of induced hyperpyrexia without benefit. The third patient developed a contralateral involvement two days after 100,000 units; he was promptly cured by an additional 200,000 units.

One patient with urethritis and a severe unilateral ophthalmia received 100,000 units plus local boric acid eye irrigations. Both conjunctival and urethral discharges ceased after 40,000 units; four days later all evidence of conjunctivitis and urethritis had disappeared, the cornea was clear, and vision was 20/20 in the affected eye.

We have encountered no penicillin-resistant cases, although one patient had a weakly positive prostatic culture after 3,100,000 units given in 7 courses; he remained clinically cured and cultures remained negative after a total of 3,775,000 units. *In vitro* his strain of organism was com-



pletely inhibited by 0.5 unit per c.c. As of the date of this writing, we have found no reported cases of penicillin resistance in gonococci, although it has been reported in pneumococci, staphylococci, and streptococci,<sup>12,13</sup> but with corresponding loss of virulence of the organism.

#### PENICILLIN AND SYPHILIS

A note of caution needs to be sounded relative to the possible masking of syphilis in these patients. Obviously exposure to gonorrhea may also involve exposure to syphilis. Since penicillin is spirocheticidal, its administration before the development of the chancre, when it will ordinarily be given in treatment of acute gonorrhea, might be expected to prevent, delay, mask, or modify the development of syphilis. While the adequate dosage for treatment of primary seronegative syphilis is yet to be established, 100,000 units is certainly inadequate but may produce healing of lesions and clinical and serological remission for as long as five months.<sup>14</sup>

Two men whose gonorrhea had been treated with 100,000 units 20 days after exposure developed dark-field positive chancres from the same exposure 7 weeks and 8 weeks later, respectively. A third patient developed two typical-looking chancres with regional lymphadenopathy on the morning that penicillin therapy was instituted, but failed to report these lesions until he had received 40,000 units. Moore et al.,<sup>14</sup> reported that organisms disappear from open lesions in 6 to 60 hours and all lesions heal, regardless of dosage. In this instance dark-field examination from the lesions was negative 5 hours after the first dose; daily examination of serum from the lesions and one of material from the enlarged regional lymph nodes all showed no treponemata, the lesions healing in 10 days. The blood Kahn test became positive 7 weeks later, nearly 10 weeks after exposure.

Penicillin may be a dangerous drug in this respect unless all patients exposed to venereal disease are given frequent physical and serological examinations for at least six months.

#### COMMENT

We can not explain why our results have not been quite so good as others have reported with the same dosage schedule. For example, Sternberg and Turner<sup>3</sup> reported 96 per cent cured with 80,000-120,000 units; 43 of 47 with epididymitis and 13 of 14 with prostatitis were cured with one course. Since a large majority of our cases were acquired in three communities within a 50-mile radius of this station, it might be supposed that a relatively resistant strain is at large in this area. However, five of the most stubborn cases of prostatitis had resulted from infections acquired elsewhere.

When one considers that 200,000 units given in 10 doses increased the cure rate in this series

of cases of anterior urethritis by only 3 per cent, it does not seem worth the additional expense and hospital day to make the routine dosage 20,000 units times 10 injections. Other studies reported<sup>3,4,5</sup> lead to the same conclusion. We did obtain twice as many cures in cases of prostatitis with 200,000 as with 100,000 units; however, the number of cases is too small to draw a definite conclusion. A dosage scheme employing 150,000 or 200,000 units given over a 12-hour period has not yet been adequately studied and reported; this merits further investigation but may prove of no advantage.

#### CONCLUSIONS

1. Penicillin is a valuable agent in the treatment of gonococcus infections. In a dosage of 100,000 units, given intramuscularly every 3 hours in 5 equally divided doses, it may be expected to cure well over 90 per cent of cases of acute anterior urethritis. Retreatment with additional penicillin cures the remainder.
2. Such complications as epididymitis and prostatitis will frequently but not always require a larger dosage. We are not now able to predict which cases will require a larger dosage.
3. Better results are not to be anticipated by previous or concomitant administration of sulfonamides.
4. No penicillin-resistant strains of gonococci have yet been reported.
5. Since penicillin may delay, mask, or modify the appearance of syphilis, all patients exposed to venereal disease and later treated with penicillin must be repeatedly examined for syphilis for at least six months.

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# Final Diagnosis: Ruptured Appendicular Artery In A Femoral Hernia

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**A**N appendix in an inguinal hernial sac is not an uncommon occurrence, and we may find it singly, or accompanied by a piece of omentum. It may be strangulated, either simple or retrograde in which type the middle of the appendix prolapses into the sac leaving the gangrenous end in the abdomen causing symptoms of hernia accompanied by pain.

The appendix may be caught high in the sac, and when the sac is opened it contains a variable quantity of turbid greyish red purulent fluid.

When the sac contains the appendix alone the lesion may vary from simple reddening and swelling to gangrene perforation or rupture, partial or complete.

In large hernia the appendix has been found posteriorly, embedded in the wall of the sac. In one of the cases reported by M. Gangolpe, such a large inguinal-scrotal hernia had become painful, red, and very sensitive to pressure. Later a scrotal abscess was opened containing a very fetid pus. The wound healed rapidly and at operation for reduction of the hernia, the appendix was found embedded in the wall of the sac at the lower end.

In another case the coecum with part of the lower ileum was found in the sac at operation along with pus. The appendix had ruptured and the end almost completely destroyed.

In femoral hernias it comes as a complete surprise when an ovary and a tube are found as the sole contents of the hernia, or when they are met within a sac containing also intestines and omentum.

However in the search of the literature, I am unable to find either in this country or abroad, a case similar to the one herein described.

Mrs. S. age 46. Family history: Father dead, cause not known; mother, five sisters and three brothers living and well. Husband and one daughter living and well.

The patient said that she noticed a bulging in the lower right quadrant two years previous to examination but ignored the condition.

Two days before admission she stepped down from a ladder, and noticed pain in the groin followed by a rapid swelling. Always before she could lie down and the swelling would disappear, but this time it continued to get worse. The pain she had seemed to be over the pubes; she came into the hospital late in the afternoon, and was admitted via wheel chair, complaining of chilliness. Blankets were applied, and at this time her complaint was abdominal pain and headache. She also stated she was hungry and thirsty. She at no time had vomited or felt

## *The Author*

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nauseated. An enema was given and returned highly colored with no feces.

The tumor mass appeared over the right groin, and was about four and one-half inches long and two and one-half inches wide and two inches high. On palpation it was extremely firm, movable to some extent, and not very tender to the touch. It extended into the right labia. On account of the extreme hardness of the mass its movability, its irreducibility, and the lack of tenderness, an exact diagnosis was not made. She was prepared for the operating room immediately, and an incision was made over the mass, with care taken not to cut deep so it could be dissected out. The mass had a very bluish black appearance and resembled a strangulated pedunculated ovary.

The stump was elevated in order to determine what it constituted. On one side it looked as though a piece of intestine were attached, and during the process of stripping the pedicle of the sac to the base the tumor collapsed.

On account of the size and thickness of the sac, the consequent unavailability for transplantation and the rapidity of the collapse, the skin was retracted and an opening was made into the abdomen.

Here there was free black blood, and upon sponging, bright blood was seen. A search for the source of this bright blood, led to the discovery of the appendix with blood spurting from the end. Two or three lobules of fat at the end were stained with the blackish blood previously mopped from the abdomen, so the appendix was removed, and a further search revealed nothing except normal intestines.

The opening of the sac was found, and inasmuch as the sac was empty, the pedicle was pulled down as far as possible, and transfixed and the sac removed.

The femoral opening and the abdomen were closed without drainage, and the skin sutured. This abdomen was closed without a drain because neither the appendix nor the peritoneum appeared to be seriously inflamed and it was felt that, although the blood had been in the sac for two days, there was little chance for infection.

The patient's only complaint following operation was a heaviness in the abdomen, and the second day her temperature reached 101.8° but returned to normal the following day. Eleven days later she was discharged from the hospital. Two weeks later she was walking around with no discomfort, and apparently recovered.

# The Clinical Application of the Blood Cholesterol Determination

ROBERT G. LEHMAN, M.D.

THE origin and metabolism of cholesterol constitute one of the enigmas of physiologic chemistry, for the substance is one of the most complex found in life<sup>1</sup> and our chemical knowledge of it is meager.<sup>2</sup> Cholesterol is a sterol, an unsaturated aromatic alcohol of which the empiric formula is  $C_{27}H_{45}OH$ . Together with neutral fats, fatty acids and phosphatids, it comprises the blood lipoids, of which it forms approximately 30 per cent.<sup>3</sup> Although not a fat, cholesterol is concerned with fat absorption and metabolism.<sup>4</sup> The normal cholesterol content of the blood plasma ranges from 120 to 250 mg. per 100 cc. Of this 25 to 30 per cent is free and the remainder combined with fatty acids as esters.<sup>3</sup>

The importance of cholesterol in biologic processes is demonstrated by its intimate relationship to numerous biochemical substances. It is among the precursors of vitamin D.<sup>5</sup> Cholesterol is one of the three main constituents of the bile<sup>4</sup> as well as the probable source of the bile acids.<sup>1</sup> It is the forerunner of the suprenal cortical secretion and the probable source of the sex hormones.<sup>1</sup> The degradation products of cholesterol include known carcinogens.<sup>1</sup>

## PHYSIOLOGIC STATES AFFECTING BLOOD LEVEL

The content of cholesterol in the plasma varies widely in health and disease, although that of the erythrocytes remains relatively constant.<sup>6</sup> Wide and rapid fluctuations in the blood level occur during the fasting state,<sup>7</sup> whereas the ingestion of butter, eggs, meat and vegetable sterols will increase the blood level.<sup>6</sup> Estimation of blood cholesterol is of value as measuring the amount present at the time the determination is made, but varies with relation to fatty meals.<sup>2</sup> Generally, a high blood level occurs most frequently where the body is forced to mobilize its own fat reserves for fuel, such as in fasting, malnutrition and diabetes mellitus, and when there is a failure to utilize the accumulated lipoids in the body.<sup>6</sup> Approximately one-half of women show hypercholesterolemia during the latter months of pregnancy.<sup>6</sup>

## The Author

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Perhaps the most useful clinical application of the determination of plasma cholesterol is to be found in the diagnosis of the nephrotic syndrome, in which hypercholesterolemia usually accompanies edema, albuminuria and decreased serum albumin content.<sup>8</sup> Values up to twice the normal may occur.<sup>6</sup> This increase may be to maintain osmotic pressure as a compensation for the loss of serum albumin.<sup>6</sup>

Boyd<sup>4</sup> quotes the investigations of Maxwell, who demonstrated that the blood cholesterol is elevated in all forms of edema of renal origin; recently published data<sup>9</sup> are in substantial agreement and indicate that the cholesterol content of the plasma is frequently increased in renal disease characterized by edema and hypoproteinemia, whether the true nephrotic syndrome is present or not. Curiously enough, in the toxemia of pregnancy the blood cholesterol is normal, despite the fact that in uncomplicated pregnancy there is hypercholesterolemia and that the "kidney of pregnancy" is of the nephrotic type and is associated with edema.<sup>4</sup>

The blood cholesterol value is usually high in hypothyroidism, particularly in well-developed stages;<sup>2,3</sup> this fact may be helpful in differentiating cardiac insufficiency due to hypothyroidism from heart failure caused by deficiency of thiamin hydrochloride.<sup>10</sup> In hypothyroidism the cholesterol values may vary from 225 to 750 mg. per 100 cc.<sup>6</sup> Conversely, low values are observed in hyperthyroidism.<sup>2,3,8,10-13</sup> Meakins considers the blood cholesterol determination of a valuable clinical aid in the early detection of thyrotoxicosis.<sup>11</sup> Peters and Man<sup>9</sup> state that cholesterol values within normal range may be found in either hypothyroidism or hyperthyroidism.

However, it is significant that "atherosclerosis (particularly of the coronary arteries) tends to be absent in hyperthyroidism and to be constant in hypothyroidism".<sup>2</sup> This is consistent

The opinions stated and the assertions made in this article are those of the writer and are not to be construed as official or as reflecting the views of the Navy Department or the Naval Service at large. Submitted October, 1944.



with the experimental finding that thyroid extract can prevent the production of atherosclerosis in rabbits fed cholesterol.<sup>2</sup>

In unregulated diabetes mellitus the cholesterol content of the blood is increased in association with the lipemia that accompanies such phases of the disease.<sup>4,8</sup> In diabetic ketosis the values often reach 350 to 600 mg. per 100 cc. The author treated a 17-year old diabetic patient who was in ketosis upon admission to the hospital. The blood cholesterol value was 800 mg. per 100 cc. This returned to a normal level promptly under insulin therapy, as is the usual experience with hypercholesterolemia in diabetes mellitus.<sup>6</sup> Rabinowitch believes that in this disease the cholesterol determination is a more consistent guide to the real condition of the patient than is the blood sugar.<sup>14</sup>

#### MISCELLANEOUS DISTURBANCES IN METABOLISM

In atherosclerosis profound alterations in cholesterol metabolism are seen. Leary<sup>1,2,15-17</sup> believes that this form of arteriosclerosis is responsible for 90 per cent of pathologic and clinical manifestations in man. This author believes that excess cholesterol is treated as a foreign body, engulfed by macrophages and transported to various sites, notably to the arterial intima.<sup>17</sup> He states that excess cholesterol satisfies all of Koch's postulates with reference to the causation of atherosclerosis.<sup>1,17</sup>

The view that deranged cholesterol metabolism causes atherosclerosis seems well supported by experimental evidence.<sup>1,17,18</sup> Anderson<sup>19</sup> admits that such derangement is probably the cause of human atherosclerosis. That the lipids in the atheroma come from the plasma seems to have been established beyond doubt.<sup>20</sup>

Cholesterol is the main constituent of the majority of human gallstones.<sup>8</sup> The concentration of cholesterol in the bile, its stability in solution and the condition of hepatocellular function are obvious factors in the pathogenesis of cholelithiasis.<sup>8</sup> An increased quantity of cholesterol in the bile is frequently associated with an increased amount in the blood, but hypercholesterolemia alone can not be said to account for gallstones, since there are a number of diseases exhibiting high blood cholesterol values (nephrotic syndrome, myxedema) in which cholelithiasis is no more common than in the general population.<sup>8</sup>

The deposit of cholesterol in gallstones seems to be a local process unrelated to such generalized disturbances of cholesterol metabolism as atherosclerosis; in accord with this belief is the fact that cholelithiasis is commoner in women than in men, whereas women are much less likely to have significant coronary atherosclerosis than men.<sup>2</sup> Nevertheless, the clinical cures following the removal of gallbladders of the "strawberry"

type (cholesterosis) without stones, seem to indicate that "removal of this one link from the chain of disturbed metabolism of cholesterol stops the process and allows a return to normal".

Perhaps the most obscure part in cholesterol metabolism is maintained by the reticuloendothelial system. In xanthomatosis of both the diabetic and nondiabetic varieties, hypercholesterolemia is present.<sup>19</sup> In the osseous form of this disease (Hand-Schuller-Christian syndrome) hypercholesterolemia is marked.<sup>8</sup> The same finding is observed in Niemann-Pick's disease whereas in Gaucher's disease there are large amounts of cholesterol present in the spleen.<sup>19</sup> A recent report<sup>21</sup> calls attention to coronary artery disease in young soldiers and reiterates the frequent occurrence of atherosclerosis in young persons with familial xanthomatosis.

#### SUMMARY

1. The chemistry and metabolism of cholesterol are complex problems of physiologic chemistry.

2. Cholesterol is concerned with fat absorption and metabolism and is intimately related to numerous biochemical substances.

3. Cholesterol metabolism is involved in an important aspect in diseases of the thyroid gland, kidney, liver, pancreas and reticuloendothelial system, and derangement of such metabolism is perhaps the chief factor in the pathogenesis of atherosclerosis.

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# When Should the Poliomyelitis Patient Be Splinted

CLARENCE H. HEYMAN, M.D.

ACCORDING to the program I have been allowed forty-five minutes to answer the question, "When Should the Poliomyelitis Patient Be Splinted". If the intent of this question is to discuss the indications for absolute and uninterrupted and prolonged immobilization I can answer in one short word "Never". Splinting in poliomyelitis is a loose term which has led to misinterpretation and abuse. A splint is a rigid device used for immobilization, and while a necessary piece of apparatus in the treatment of fractures and other miscellaneous conditions, it leads to atrophy, muscular weakness, interference with circulation, adhesions, bone atrophy, and other undesirable effects.

I am going to assume, therefore, that it was the intent of the question to be, "When Should the Muscles of the Poliomyelitis Patient Be Protected", for this is quite a different matter and can not be answered so curtly. It depends upon many things among which are the degree and location of the muscular weakness, the amount of pain or muscle spasm, the condition of the ligaments supporting the joint, the relative strength of the opposing groups of muscles, the duration since the onset of the disease, and many other conditions. There are some patients who require no protection at all, and others who may require protection of muscles for years or the remainder of their lives.

## REST

Now, as I see it, the principles as laid down by Robert Lovett have been generally adopted by orthopedic surgeons and physical therapists, but as so often happens spurious and vicious modifications have arisen with the common error, for instance, that if a certain amount of rest and protection is good, prolonged and complete immobilization is better, leading to the ill effects of mismanagement. It is not to be wondered that many patients with no treatment whatever got along better than those who were immobilized for many months. Briefly stated, Lovett advocated rest and the use of heat during the period of tenderness and spasm, devices to prevent contracture and stretching of weakened muscles, graduated muscular exercise with the careful avoidance of fatigue, and re-education in the use of muscles. These are the broad underlying principles of what we have adopted as the rational treatment of the weak muscle. Each patient is

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an individual, for there are no two alike in all respects. Hence, there is no so-called—and I do not like the term—orthodox or conventional treatment.

Now since the validity of these principles has been questioned and a crusade has been directed against an imagined orthodoxy with a sympathetic response on the part of the public, let us not be too complacent that our treatment is, after all, the rational one. Let us re-examine our methods. Are they sound? They have been handed down from teacher to pupil for so long a time now that it is possible they have become so garbled and distorted and embellished as to resemble in only a faint way the original sound treatment of Lovett. Or again, was the teaching of Lovett sound? Progress has been made, of course, but changes do not necessarily mean progress.

## THE PATHOLOGY

In order to reach any conclusions let us briefly re-examine what we know concerning the pathology and pathogenesis of poliomyelitis and the physiology of muscles, as it pertains to movements, and critically appraise our end results as compared with other methods.

A peripheral nerve has a cable-like pattern in cross-section composed of funiculi or bundles, each of which supplies a limited portion of muscle so that a minimal contraction to stimulation of the nerve results in a contraction of only that part of the muscle whose motor fibers are stimulated. A muscle is not a single unit or homogenous structure where a minimal stimulation causes all of it to contract very slightly and a progressively stronger stimulation proportionately causing a stronger and stronger contraction.

Skeletal muscle, as well as heart muscle, contracts according to the all or none law. The

Read at the Review Course on the Treatment of Poliomyelitis in the Early Stage of the Disease, Cleveland, July 5, 1944.



muscle fiber contracts to its maximum or none at all. A stronger stimulation does not result in a stronger contraction of the muscle fiber. It is true that up to a certain point a stronger stimulation results in a stronger contraction of the entire muscle, but this is through a spread of the stimulation to affect other motor axones and muscle cells until all are stimulated resulting in a maximum contraction. Further stimulation will not produce greater contraction.

These grossly recognizable and identical bundles in the peripheral nerve are in turn composed of so-called "motor units". From each anterior horn cell in the spinal cord the axone passes through the anterior root and down a bundle to the muscle. "Here, just before and after entering the muscle, it breaks up into many collaterals which, in the mammalian limb, supply from 100 to 160 fibers."<sup>1</sup> The motor neurone with the collection of muscle cells it supplies is called a "motor unit". A destruction of a single anterior horn cell will result in a paralysis of a minute portion of the muscle. Many anterior horn cells destroyed will result in a proportional weakness, and destruction of all the motor neurones will result in a complete paralysis. The effect upon the muscle of an incomplete lesion is spotty. Some portions may be normal; others are degenerated.

#### EDEMA?

The common conception that poliomyelitis is a general systemic disease in which the anterior horn cells are peculiarly susceptible and that a transitory paralysis or weakness is the result of the disappearance of an edema with release of pressure on the nerve nuclei is likely erroneous. The virus is not so active as to produce an edema.<sup>2</sup> The effect of the virus upon the nerve cell may not be lethal and recovery of its function may occur. Hence, rest or immobilization of the affected muscle is not indicated in order to prevent further edema and exudate in the cord and to promote its absorption as has been so commonly stated.

It may be possible that irritation of a muscle may result in changes in the cord, but if work has been done along these lines I am not familiar with it. It has been reported by some, however, that the anterior horn cells soon become smaller in size and number in an irritative lesion in the joint as tuberculosis, but this work has not been confirmed by others. A complete cessation of connection of an extremity as in amputation results in trophy and disappearance of the anterior horn cells innervating the part lost. We can not conclude from this, however, that lack of use alone of a normally innervated muscle results in any change in the cord. If an investigation were to prove that degenerative changes in the anterior horn or axone follow simple fixation of the part innervated it would be quite convincing that im-

mobilization in the treatment of poliomyelitis is harmful in that respect.

It appears, therefore, that immobilization or splinting or protection of an extremity has no place in the treatment of poliomyelitis for whatever effect it may have on the prevention or absorption of any edema or exudate about the anterior horn cells. On the other hand we do not have any conclusive evidence that immobilization for a limited period of time has any untoward effect upon the nerve cells. We realize, of course, that there is a muscular atrophy of disuse and that there is an early atrophy accompanying joint disease or injury; but the former is likely local in origin in the muscle from a disturbance in metabolism, and the latter likely a reflex phenomenon.

#### LESION IN THE CENTRAL NERVOUS SYSTEMS

Let us now briefly examine the effect of the disease upon the central nervous system. The virus spreads from a local focus in the gastrointestinal tract or possibly from the skin through the regional nerves and posterior nerve roots affecting the cells in the posterior root ganglia, the cells in the anterior horn, and lateral nuclei and passes upward through the tracts of the cord to damage neurones in the medulla, cerebellum, and particularly the motor cortex of the cerebrum in areas four and six.

Nurones are quickly destroyed. The virus may lie dormant without any apparent effect upon the muscle, but paralysis may appear through muscular effort or local injury. This suggests that the patient be at rest and his muscles protected immediately when the disease is suspected. We know, of course, that destruction of an anterior horn cell results in paralysis and degeneration of the muscle fibers innervated by it, and if a sufficient number of nerve cells are destroyed objective evidence of weakness or paralysis becomes manifest. We know too that injury to the nerve cell sufficient to destroy it causes a permanent paralysis whether treated by this method or that, and that an incomplete paralysis means that all nerve cells innervating the muscle are not destroyed. The effects upon the muscle are only secondary to the nerve damage.

#### SISTER KENNY

I shall not enter into any controversy upon these facts for the sake of combatting Sister Kenny's concept that muscle spasm causes paralysis. Many investigators have further studied the pathology and abnormal physiology of poliomyelitis with the aid of modern methods such as the use of action currents<sup>3</sup> and chronaxia<sup>4</sup> resulting in further proof that paralysis is neurogenic in origin and is secondary to nerve damage. Let us not waste time on that. While her concept of the pathology is erroneous, it does not neces-

sarily follow that her treatment is not good. Malaria was successfully treated by quinine long before anything was known about its cause or pathology.

#### CHANGES IN THE MUSCLES

Our next consideration is an examination of the pathological changes in the muscles. This has received comparatively little study and my own knowledge concerning this important subject has been limited to a vague conception of atrophy and degeneration.

I am indebted to Hipps<sup>1</sup> for a clarification of the subject. Hipps' pathological studies nicely correlate what we have said regarding the pathology and physiology and what we have learned by experience. Destruction of motor nuclei results in atrophy and fibrous or fatty replacement of the muscle fiber and an interfascicular fibrosis with permanent loss of function or contractile power. There may be a temporary impairment of function of the muscle cell when the virus has not caused irreparable damage to the nerve cell. In the presence of a permanent disintegration of a sub-total number of units in the muscle improvement in strength occurs through hypertrophy of the intact muscle fibers, and apparently not through hyperplasia or newly formed cells.

To function properly a muscle must be in a certain amount of tension. If tension is lost, as in the complete approximation of the origin and insertion of the muscle or following section of the tendon as in tenotomy, it can not contract since its fibers are already as short as they can be, and secondary changes identical with denervation occur.

Tension may be lost on intact muscle units by tears of its surrounding supporting tissues or loose fatty replacement. Too great a tension or overstretching causes multiple minute tears in the muscle described as "stretch tears", and hence weakness. In addition to the primary effects of denervation there are secondary effects resulting from too great a tension or stretching, too little tension as allowing the origin and insertion of the muscle to remain unduly approximated, and the changes following disuse. These secondary changes produce just as much weakness in the muscle as does primary degeneration. A knowledge of these facts is of practical value in the treatment of poliomyelitis.

While the predominating and immediate picture of poliomyelitis is paralysis, changes occur in other structures as in the bones, ligaments, joints, muscular septae, and fascia. Bone atrophy occurs. The bones become demineralized and are soft, easily broken and their rigidity and shape less resistant to pressure and strain. This may be the result of a primary neurotrophic disturbance or a result of disuse or disturbance in peripheral blood supply.

While a ligament is an inelastic structure and

will tear rather than stretch on a suddenly applied force, it will become elongated and unsupported upon prolonged strain which is particularly likely to occur in the absence of the support of good muscles. Hence, the importance of support or protection to the bones and joints in the presence of muscular weakness.

Deformity in poliomyelitis is not the result of a single acute force, but follows as a result of a comparatively less severe force often repeated or a constantly prolonged one. On the other hand, immobilization results in contracture and the formation of adhesions in periarticular structures or muscle spaces with loss of active and passive motion, pain, and inability to exercise the muscle efficiently.

#### THE PLACE OF EXERCISE

So far we have discussed the untoward effects of immobilization: stretching, loss of tension, atrophy of disuse, and adhesions. Let us now consider the place of exercise and the possibly ill effects of an active modality of treatment. It is desirable, of course, to build up the strength of the muscle through hypertrophy of the remaining fibers by the judicious use of exercise. Our chief concern here is the timing of active exercise and the amount.

Muscle spasm is present in the acute painful stage of poliomyelitis, and the pain is due to or an accompaniment of the muscle spasm. Spasm does not initiate paralysis, but it does impair the function of muscle. Obviously a muscle can not be exercised in the presence of spasm, and we know that any local irritation increasing the proprioceptive impulses aggravates or prolongs muscle spasm.

Measures to relieve muscle spasm as quickly as possible are rational. Heat does not relieve spasm.<sup>3</sup> The most practical and efficient way to relieve spasm is by rest or traction. Now how this rest is accomplished is a matter of common sense. Bed rest, of course, is important, and whether one applies a so-called splint or other protective device is immaterial as long as the muscle is protected from irritation and activity, supporting the muscles in the optional position as regarding tension and bearing in mind the antagonistic as well as the weakened agonistic muscle.

Let me say here that there is great confusion as to the recognition of spasm. It is a common error that, even after weeks of protection and rest or even splinting, spasm is assumed to be still present when passive motion is resisted or is painful, and still further rest is prescribed. Pain and limited motion in many cases is the result of fibrosis, a contracture, or adhesions which require motion to overcome. The timing, therefore, of early, gentle, passive motion in the presence of paralysis is important. One must prevent adhesions, but one must also be cautious to avoid the "stretch tears".



#### INDICATIONS FOR ACTIVE EXERCISE

With the subsidence of muscle spasm active exercise is indicated. Here our chief concern is the avoidance of fatigue. Fatigue is caused by a deficient circulation resulting in an incomplete metabolism and an excessive amount of lactic acid. The excursion of a muscle in fatigue is less and an overload will stretch it. I do not know whether fatigue short of tetanus will result in a permanent or irreparable change, but certainly a muscle can not hypertrophy and gain strength in the presence of fatigue.

A muscle with only a small portion of its units intact will fatigue much earlier when every one of its units must work according to the all or none law to produce simple movement. It is here that the skill of the physiotherapist meets the test: graduated exercise with the avoidance of fatigue and to know when to stop. To improve local circulation and lessen the likelihood of fatigue, heat and massage are useful. Let us not forget that circulation to a muscle can be improved not only by local measures, but also by general muscular exercise as walking or swimming through the effect upon increasing the cardiac output; bearing in mind, of course, the protection of the weak muscles, local fatigue, and the harmful effects of substitution.

#### CAN REST BE OVER DONE?

We have now with this background finally reached our subject: "When Should the Poliomyelitis Patient Be Splinted"? or rather when should the muscles be protected. This question should not be difficult to answer, but can be answered only in generalities and not beforehand specifically in any one case. Each case is an individual one. Intelligent orthopedic treatment demands that we have knowledge not only of the primary effects of the nerve damage, but, of equal or even greater importance, knowledge of the secondary effects as well. It also demands a knowledge of the untoward effects of injudicious or unusually prolonged fixation and rest.

John Hilton in his classic, "Rest and Pain", taught that pain was a symptom demanding rest. He had no use for massage, movements, or exercise. Hugh Owen Thomas said, "I can not find suitable cases upon which I would perform the deception known as passive motion."<sup>6</sup> While undoubtedly they did not have particular reference to poliomyelitis their teaching in joint inflammations and injuries has prevailed to this day, and are acceptable with reservations in the case of poliomyelitis. In other words, there can be an overdose of rest.

Now let us examine the evidence gained by practical experience in the treatment of a weak or paralyzed muscle. Are our methods of treatment misdirected in the light of what we know about the fundamentals of the primary and sec-

ondary pathological changes in poliomyelitis and the application of knowledge of the physiology of the nerve-muscle mechanism?

Practical experience has taught us general principles in the treatment of muscle weakness from whatever cause: Peripheral nerve injuries, obstetrical paralysis, trauma to muscles, fractures, spastic paralysis, faulty position in bed, and various other causes. These are: (1) prevent stretching of the weak muscle, for stretching prevents it from regaining power or may result in a physiological paralysis; (2) prevent contracture by not allowing the origin and insertion of a good antagonistic muscle to be maintained in approximation; (3) a steady and constant pull on a muscle decreases spasm, while a jerky interrupted stretch aggravates spasm; (4) prevent the stretching of the supporting ligaments of a joint particularly in the presence of weak muscles.

These necessitate some sort of an appliance such as a splint, a brace, or any device as a block of wood or board at the feet to prevent foot-drop. If it does the job we have no quarrel with the details as long as constriction to interfere with the circulation of blood and lymph is avoided. Stasis or edema leads to fibrosis. The necessary prevention of stretching also prevents contracture and deformity.

One must be cautious, however, in the use of these devices and prevent adhesions and atrophy of disuse. It is true that a healthy joint will not become ankylosed by immobilization alone, but dense adhesions and shortening of muscle may markedly limit motion. Actual experience has taught us also to avoid fatigue in exercise, and to stimulate the circulation of blood and lymph by heat and massage. Of course a muscle can not be exercised and adhesions prevented when keeping a splint on all the time, so there comes a time when the appliance must be removed.

There must be a proper balance between protection and exercise. Prolonged splinting will prevent stretching and deformity, but it is not conducive to muscle strength. Unrestricted position will lead to contracture and overstretching; overuse will lead to fatigue and weakness.

#### MUSCLE PROTECTION

When do we begin the protection of the muscle? It should be applied uninterruptedly early in the course of the acute disease provided it does not seriously interfere with the treatment of the emergency, for it is by rest and protection that muscle spasm is eliminated. How long is uninterrupted protection continued? Until muscle spasm has subsided, for we can not exercise a muscle in the presence of spasm. After muscle spasm disappears—and we must be able to differentiate pain caused by spasm from that caused

by adhesions—protection of some sort is necessary during the period of convalescence or until the patient has made his maximum recovery—not the uninterrupted protection or splinting, but the reasonable one to prevent stretching and contracture and fatigue with removal of the apparatus to permit applications of heat, massage and exercise.

There are no subjective warning signs of a local fatigue involving a single muscle or a small group of muscles as is manifested by a feeling of distress in fatigue caused by an insufficient cardiac output in general muscular exercise. Hence, the weak muscle must be protected. After the period for maximum recovery, and most patients will reach that stage in 12 to 18 months provided they have had proper treatment from the beginning, protection may be required indefinitely for the lower extremities or back to prevent a progressive stretching of ligaments and joint instability. It is easy to focus attention only to an obvious paralysis, overlooking the damage that may be caused by stretching of ligaments or the deforming force exerted upon the bones. These structures must be protected for as long a period as there is a need.

One hears it claimed that deformities can be prevented without the use of any appliance. Of course they can, for approximately 70 per cent of all cases make a complete recovery without any treatment. But when it is claimed that serious paralytic cases with imbalance of the opposing groups do not require protection to prevent deformity, that is simply not true. Neither can we prevent some deformities by the use of any known device.

It is said again that scoliosis does not occur under this or that treatment. This again is not true, for if the cases are followed long enough scoliosis will be seen. One who does not follow his cases two or three years at least can make no claim that scoliosis does not occur, for it usually takes that length of time for a structural scoliosis to develop, and sometimes longer. Splinting or braces will not prevent it either, and nothing to my knowledge will. Neither can we assuredly prevent some other deformities, but we know for a certainty that they are far less frequent by proper care. There has been a markedly lessened incidence in the number of severe deformities resulting from poliomyelitis. This must be the result of better treatment, and with proper protective measures it can become still less.

#### SPLINTING

A splint, or whatever apparatus is used, requires a knowledge of its adaptation and a skill in its application and use. Improper splinting causes more harm than good, and unless the attending physician has a reasonable amount of skill in the use of splints it would be better if

none were used at all. It is not surprising that an unqualified man will have better results without them, and do better by letting nature take its course. Splints must avoid pressure, edema and stasis, and must be comfortable. They are valuable assets, but in the hands of the unqualified may do great harm whether it be the Toronto splint, the Bradford frame, the plaster splint, or what not. Improper splinting sometimes causes irreparable damage to even normal muscles, and still greater care is required to muscles damaged by poliomyelitis.

#### CONCLUSION

A careful and critical re-examination of our concepts regarding the treatment of the muscle in poliomyelitis leaves me convinced that we have been on the right track and that splinting or protection is of great importance. This implies, however, responsibility.

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#### Milk-Borne Carcinogen

For a number of years the staff members of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, have made genetic studies of spontaneous tumors in several intensively inbred strains of mice. Under natural methods of propagation, these strains showed widely different hereditary tendencies to the development of spontaneous breast tumors. At one end of the scale there were certain families, 95 per cent of whose members eventually died of mammary carcinoma. At the other extreme there were families in which the incidence of spontaneous breast tumor was as low as 0.5 per cent.

About 10 years ago the natural method of propagation was purposefully or inadvertently altered, many of the young being reared by foster mothers. It was then noted that the fostered young tended to acquire the carcinogenic percentage of the foster parents. Thus, a 94.7 per cent susceptible strain was changed to a 0.7 per cent strain as a result of refractory (0.5 per cent) foster-feeding. A 0.5 per cent (refractory) strain became highly susceptible (89.8 per cent) as a result of 95 per cent susceptible foster-feeding.—W. H. Manwaring, M.D., Palo Alto, Calif.; *Calif. and West. Med.*, Vol. 62, No. 3, March, 1945.



# Multiple Venous Thromboses With Associated Carcinoma Of the Pancreas

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Case 191427. H.B., a 49 year old white married male, entered the hospital because of sudden paralysis of the left arm and leg the night before admission.

**History** (Obtained from wife): The patient had always enjoyed good health. He had been told he had hypertension many years ago. Six months before admission there began gradual anorexia, weakness and weight loss, the latter amounting to 40 pounds by the time of admission. He was able to continue his work as a shirt cutter until 6-7 weeks before admission when he finally had to take to his bed because of weakness. A few weeks before, a chronic cough, productive of blackish sputum, appeared and about the same time he developed diarrhea consisting of bulky, light colored stools, 6 or 7 per day. On a number of occasions these stools contained blood and once or twice were tarry. At this time the patient, also, noted rather sudden and painful swelling of the right foot and leg and a few days later similar, but less marked, swelling of the left leg. The patient's condition deteriorated rapidly from this point. A few days before admission swelling of the left hand was noted, and gross hematuria appeared for the first time. The night before admission the patient suddenly became unable to enunciate words, could not recognize his wife, and the left arm and leg were noted to be flaccid and paralyzed.

**Physical Examination:** Temperature 100.6° F.; Pulse 116; Respiration 22; Blood pressure 128/76 mm. Hg. The patient was a well developed but emaciated and chronically ill white man lying quietly in bed. His eyes were open and wandering. From time to time he mumbled incoherently. He seemed unable to comprehend the spoken word or to speak, and the level of consciousness was reduced. The skin was normal. Pupils were equal, regular, 6 mm. in diameter and reacted to light. Optic fundi showed no abnormalities. Many teeth were missing. He would not open his mouth or protrude the tongue. Trachea was in the midline. A firm nodule, 1 cm. in diameter, was noted in the right lobe of the thyroid. The chest was symmetrical.

Examination of the lungs revealed no abnormalities on percussion, palpation or auscultation. The heart was not enlarged and no murmurs were heard. The abdomen was moderately distended. A huge, stony hard and grossly nodular liver was felt extending five fingers below the right costal margin. There was a sense of fullness in the epigastrium. Veins over the left upper chest and right lower abdomen were prominent. Rectal examination revealed fair tone and a walnut-sized polypoid mass at the tip of the examining finger. Genitalia were normal. There was a 2+ pitting edema of the

right leg. There were shotty bilateral inguinal nodes.

Neurological examination revealed left facial weakness of the central type, flaccid paralysis of the left arm, paralysis of the left leg with decreased tone. The deep tendon reflexes were normal on the right side and hyperactive on the left. The abdominal and cremasteric reflexes were present on the right and absent on the left. Plantar reversal signs were present on the left. There was unsustained clonus of the left ankle. No disturbances in sensation could be elicited.

**Course:** The course was progressively downhill. The patient's level of consciousness became further reduced. He was incontinent of urine and feces and in the nurse's notes the latter were noted to be large and "clay-colored". On the second day there was protruded from the rectum a large polyp which bled. This was doubly ligated and removed. The report of the surgical pathologist was adenomatous polyp of the rectum, and it was not thought by him to be malignant. Following this the patient continued to ooze blood from the rectum. He lapsed into coma and died on the ninth day.

**Laboratory Data:** Venous pressures were 16 cm. H<sub>2</sub>O in the right antecubital vein and 17 cm. H<sub>2</sub>O in the left femoral vein. The spinal fluid pressure was 120 mm. H<sub>2</sub>O initially and 40 mm. after 15 cc. fluid had been removed. The cerebrospinal fluid was clear and contained 2 WBC, 372 RBC per cu. mm. The cerebro-spinal fluid protein was 45 mgm. per cent, chlorides 724, sugar 51 mgm. per cent, and the Wassermann was negative. Blood laboratory findings were: Hemoglobin 9.0 gm.; RBC 3.76 million; WBC 14,700, with 78 per cent PMN's, 5 per cent lymphocytes, 17 per cent monocytes; urea nitrogen 15 mgm. per cent; CO<sub>2</sub> combining power 54 Vol. per cent; icterus index 5; cephalin flocculation 2+ in 24 hours; Wassermann negative. No urine or stool specimen was examined.

## CLINICAL DISCUSSION

The story is that of a man who developed a nonfebrile debilitating disease which was finally complicated by a migratory thrombophlebitis and terminated by disease in the brain, lungs, kidneys and liver.

The debilitating nature of the disease and the character of the liver findings suggest carcinomatosis. The severe nature and prolonged course of anorexia, loss of weight and weakness are unusual for a primary carcinoma of the liver. Primary carcinoma of the gastrointestinal tract is suggested, especially by the presence of rectal polyps, but the absence of signs of obstruction are against an intrinsic lesion of the gastrointestinal tract, though a polyp, irritated by diarrhea may have caused the sporadic appearance of blood in the stools. Also, the polyp was proved to be benign by biopsy. The diar-

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This is the twenty-second in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.



rhea with bulky stools and the extreme weakness of the patient suggest carcinoma of the pancreas. The development of migratory phlebitis, though it occurs in other types of cancer, is especially common in carcinoma of the body of the pancreas and therefore strengthens the likelihood of this diagnosis in this case.

The venous pressure is moderately high and equal in the upper and lower extremities. The equality of these pressures is to be expected in heart failure or from obstruction to venous inflow by moderate pericardial tamponade. Neither explanation is satisfactory for two reasons: first, there are no signs of either disorder; and, second, the spinal fluid pressure, reported as 120 mm. water should have been approximately equal to that in the peripheral veins; namely, 160—170, had there been a generalized increase in venous pressure. The elevated femoral venous pressure could mean a partial femoral venous obstruction, due either to thrombosis or to the increased intrabdominal pressure present in this case in association with the abdominal distention. The elevation of the antecubital venous pressure in this case is most likely due to a venous thrombus located proximal to the point of measurement. On the other hand, these venous pressures are not very high and may be due to errors in measurement.

Are the complications in the brain and kidney and lungs due to emboli of metastatic tumor or to the widespread thrombophlebitis present in this case? The cough without acute attacks of pleural pain would suggest metastasis to the lungs rather than pulmonary infarct from thrombus emboli. Emboli to the brain and kidney could arise from dislodged venous thrombi in the presence of a septal defect or from the left heart if thrombi had formed there, as they sometimes do in phlebothrombotic disease. They could also arise from tumor growth in the lungs.

There is suggestive evidence of widespread cerebral involvement. The patient not only had a lesion of the right internal capsule, but the aphasia, the marked changes in level of consciousness, and suggestive signs of involvement of several cranial nerves suggest more widespread involvement. Since venous thrombi are known to be widespread in this case, and the presence of red cells in the cerebrospinal fluid suggest thrombosis rather than establishment of emboli, the diagnosis of widespread thrombosis of cerebral veins is favored. Thrombosis of renal veins will also account for the episodes of hematuria.

**Clinical Diagnosis:** Primary carcinoma of body of pancreas with metastasis to the liver and lungs; thrombophlebitis migrans involving the peripheral veins of all extremities, and the veins of the brain and kidneys.

**Necropsy (N-44-116):** The necropsy was performed four hours post mortem.

**Gross Examination:** 1000 cc. of clear yellow fluid was present in the peritoneal cavity, the lining of which, superiorly and throughout the pelvis, was studded by innumerable pinkish-white, firm, nodular and plaque-like masses, three to fifteen mm. in diameter. The omentum was thickened, rolled, extensively infiltrated by similar masses, and adherent to surrounding structures. A purplish-blue, fluctuant mass, ten cm. in diameter, was adherent to the posterior wall of the fundus of the stomach and to the body of the pancreas. This mass contained a large amount of cloudy brownish fluid and was generally lined by a white glistening membrane. No communication between the stomach and the cyst-like mass could be demonstrated. The head of the pancreas, externally and on section, appeared normal; the body, however, was invaded by small confluent nodular pinkish masses and appeared to blend into the wall of the cyst and the prevertebral tissues. The lining of the cyst, in the region of the body, was tough, nodular, and somewhat eroded. The tail of the pancreas was represented by a small mass of indurated, lobulated, yellowish-white tissue, infiltrated by nodular pinkish-white tissue. It was adherent to the antero-inferior aspect of the cyst wall.

The liver, markedly enlarged, weighed 3,790 grams and presented, in the right lobe, a pinkish tan, focally softened mass, 20 cm. in diameter and multiple small, slightly umbilicated nodules, varying in size from one-half to four cm. in diameter, throughout the other lobes. The intervening liver substance was generally soft, mottled reddish and yellowish-brown. The hepatic aspect of the gall bladder was thickened by firm white tissue. The biliary passages were patent and appeared normal. The pancreatic duct was not explored.

Throughout the visceral pleura of both lungs there were numerous plaque-like pinkish-white masses, three to five mm. in diameter. Similar but smaller nodules were sparsely distributed throughout the lung substance. The lungs were of increased weight and presented evidences of acute confluent lobular pneumonia.

The tracheobronchial, mesenteric and hepatic lymph nodes were enlarged and infiltrated by neoplastic tissue. Those at the porta hepatis formed a mass four cm. in diameter which surrounded and slightly constricted the portal vein.

The mucosa of the gastro-enteric tract was of normal rugal pattern and was remarkable only for focal areas of bile staining and congestion. In the rectum, however, there were three pedunculated polypi. The largest of these, five by three cm. in dimensions, was reddish-black, friable, and protruded from the anus. Otherwise the rectal mucosa was normal.

The right common iliac and left brachial veins, a right intrahepatic branch of the portal vein, and the right middle cerebral artery were occluded by soft, purplish-red thrombi. A dry laminated pinkish-tan thrombus partially obstructed the left pulmonary artery. Exploration of the extra-hepatic portal venous system failed to reveal a thrombus.

The spleen, 215 grams in weight, presented an old and a recent infarct; these were approximately two by three cm. in measurements. Scattered throughout the cortices of the kidneys, which together weighed 360 grams, there were innumerable, small, reddish-tan infarcts. Examination of the brain revealed an area of recent softening in the gray matter of the right cingulate gyrus and an old cystic area of softening



in the depths of the right Sylvian fissure. The brain weight was 1325 grams. The heart was normal except for a firm oval white area, six mm. in diameter, in the left ventricular myocardium. There was slight atherosclerosis of large and moderate sized arteries.

**Microscopic Examination:** Representative sections of the tail and body of the pancreas disclosed dense connective tissue permeated by numerous large and small irregular ducts. Many of these ducts presented a relatively normal appearance in that they were lined by clear, tall, cylindrical ductile epithelium; however, focally, there was a slight loss of polarity, mitotic figures, and hyperchromatism. Other ducts were lined by large, irregular, granular, hyperchromatic, cylindric cells and presented papillary epithelial masses. Usually, in the latter ducts there were numerous mitotic figures, invasion of vascular spaces, and destructive infiltration of the supporting framework. In addition there were other areas in which the cells were of low cuboidal or polyhedral type, anaplastic, and arranged in acinar structures. No recognizable normal tissue was present in the distal portion of the body or in the tail of the pancreas. Neoplastic tissue was not demonstrable in the head. The distal portion of the splenic artery was occluded by an organized partially recanalized thrombus.

An epithelial lining was not demonstrated in the cyst-like pancreatic mass; however, that portion continuous with the body of the pancreas was infiltrated by anaplastic columnar cells.

Similar neoplastic tissue infiltrated the hilum of the spleen and the coeliac plexus. In the latter structure ductile reproducing neoplastic tissue was present in the perineural spaces and, in areas, within the nerve bundles themselves. Generally, the nerve fibers were intact; however, occasionally there was considerable degeneration and necrosis. Throughout the liver, particularly the right lobe, there were large, extensively necrotic and focally liquefied metastases. The remaining liver tissue presented central zonal necrosis and hepatitis, marked chronic passive hyperemia, and minimal biliary stasis. Miliary metastases were present in the lungs, and were located in the peribronchial and periarterial lymphatics. In addition an acute confluent lobular pneumonia was present. The tracheobronchial, mesenteric, and hepatic lymph nodes were extensively invaded by ductile neoplastic tissue. Plaque-like masses of neoplastic tissue were present in the pleura and peritoneum.

Examination of the rectal polypi disclosed no evidences of malignant change. That which protruded from the anus was necrotic, infiltrated by neutrocytes, and the intrinsic veins of the contiguous rectal wall presented a well established suppurative thrombophlebitis.

The multiple thrombi seen grossly were of recent origin, in that they consisted of laminated zones of fibrin and blood cells, and where adherent to the vessel wall there was only minimal fibroblastic invasion. However, the thrombus in the left pulmonary artery consisted of an adherent, amorphous eosinophilic mass with a superimposed recent fibrino-cellular clot. This amorphous clot, containing capillaries and free hemosiderin, was partially covered by connective tissue and endothelium continuous with the artery wall. More striking, though, were the numerous thrombi noted microscopically in the brain, heart, head of the pancreas, liver, kidneys, and lungs. These thrombi, predominantly in-

volving venules and rarely arterioles, consisted of fused platelets, indistinct erythrocytes, and nuclear remains of leucocytes.

Generally, the thrombotic material was adherent to one or more points on the vessel wall and was apparently of various ages. What appeared to be the earliest thrombi often consisted of a pedunculated platelet clot. A later stage was suggested by those which were partially covered by endothelium. Others, being adherent to the vessel wall at several points and being covered by endothelium, had the appearance of recanalized thrombus. Those which appeared as an intimal hump covered by endothelium seemed to be the oldest as they blended into the vessel wall and were composed of masses of eosinophilic amorphous material without recognizable cellular elements. These venules and arterioles were not related to neoplastic disease, did not contain tumor emboli, and were not associated with an inflammatory reaction.

Recent and old disseminated areas of encephalomalacia and the numerous recent renal infarcts were in direct relation to the thromboses in both venules and arterioles; however, arteriolar thrombi were not demonstrable in relation to organizing miliary myocardial infarcts. The splenic infarcts are probably dependent upon the changes in the splenic artery, for thrombi were not demonstrable in the splenic arterioles.

**The Principal Pathologic Diagnoses were:** Carcinoma of the tail and body of the pancreas with direct extension to the regional lymph nodes, coeliac plexus, and splenic hilum and metastases to the liver, lungs, pleura, peritoneum, tracheobronchial, mesenteric and hepatic lymph nodes; multiple old and recent venous and arterial thrombi; multiple infarcts of the heart, spleen, kidneys and focal areas of encephalomalacia; acute confluent lobular pneumonia; rectal polypi with suppurative thrombosis of the intrinsic rectal veins; pseudocyst of the pancreas; ascites.

#### PATHOLOGICAL DISCUSSION

This case demonstrates most of the salient features of carcinoma of the tail and body of the pancreas. Absence of jaundice, extensive hepatic and abdominal lymph node metastases and widespread peritoneal implantations have been shown by Duff's critical analysis<sup>1</sup> to be highly characteristic and in sharp contrast to the identifying characteristics of carcinoma of the head of the pancreas. Recent papers<sup>1,2,3,4,5</sup> have emphasized the frequency of this lesion, in that those of the tail and body comprise one-third of all carcinomata of the pancreas. Being in contact with the peritoneum, and the tail occasionally even being intraperitoneal, the tail and body are strategically located to give rise to early and widespread peritoneal implantations. Also, extensive and massive hepatic metastases found in carcinoma of the tail, in contrast to those of the head, are probably due to the intimate relationships of the body and tail to the splenic vein which lies deep in a groove on their posterior surface. There is no adequate anatomical explanation for the more extensive lymph node involvement found in carcinomata of the tail in contrast to those of the head; however, this and



the ease of hematogenous spread may in some way be related to the development of the gland, as the head is of different derivation from the remainder of the organ.

The extensive involvement of the coeliac plexus would suggest that pain should have been a conspicuous symptom in this case. A recent study<sup>4</sup> has shown that the coeliac plexus is often involved in carcinomata of the tail and body, and that pain is a frequent and an early symptom. It also has been noted that in some instances there is no history of pain even though the coeliac plexus is markedly infiltrated.

Peritoneal neoplastic implants, extensive intrahepatic metastases, marked enlargement of the lymph nodes at the porta hepatis with constriction of the portal vein are adequate together to explain the ascites.

The cyst-like mass continuous with the body of the pancreas should properly be regarded as a pseudo-cyst, for no epithelial lining could be demonstrated. Actually, however, it is almost impossible to distinguish between true and false cysts as the former may lose their epithelial lining. Pseudo-cysts are usually single, spherical, tense, often arise from the body or tail, and are not associated with cysts in other organs.<sup>6</sup> Pseudo-cysts, frequently preceded by trauma, are thought to arise either as a result of encapsulation of blood in the lesser peritoneal sac, or as the result of liquefaction of the pancreas by liberated ferments with subsequent dissection into the various peritoneal reflections. In this case the position of the cyst within the gastro-colic ligament would suggest that ferments were liberated either as a result of pancreatic necrosis from vascular occlusion or by neoplastic interruption of the ducts. Only one other carcinoma of the pancreas with an associated pseudo-cyst was found in the literature.<sup>5</sup>

Widespread venous thromboses have been frequently described in association with carcinoma. In various clinical and necropsy series carcinoma has been noted to be second in importance as a cause of thrombosis. Sproul<sup>7</sup> studied the problem of venous thromboses in relation to carcinoma and found that of all cases, those of the tail and body of the pancreas were most frequently associated with venous thromboses. In his series, of those located in the tail and body, 56 per cent had single or multiple venous thromboses, whereas of those in the head thrombosis occurred in about the same percentage as other carcinoma, 15 to 25 per cent. It has been noted,<sup>7,8</sup> also, that frequently with multiple venous thromboses there are similar thrombotic deposits on the mitral and aortic valves. In the reported cases the thrombotic deposits were not associated with tumor emboli and the involved vessels were free of the local factors which lead to thrombosis.

Studies have been done which indicate that in

carcinoma generally there is an increased coagulability of the blood, and other studies indicate that in carcinoma of the tail and body of the pancreas that there is an exalted production of ferments. On the basis of the ferment studies, it has been suggested that in carcinoma of the tail and body of the pancreas there is increased assimilation of those substances known to be essential for blood coagulation, cephalin, protein, and vitamin K.<sup>7</sup> However, it should be remembered that similar diffuse thrombotic disease may accompany carcinoma of organs other than the pancreas, as for example the bronchus.<sup>9</sup>

The widespread venous and arterial thrombi in this case are therefore consistent with findings in other reported cases of carcinoma of the tail of the pancreas, and readily explain the clinical evidences of disseminated venous thrombotic disease.

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#### Endometriosis

The occurrence of mature functioning endometrium in ectopic locations, though rarely diagnosed ten years ago, is rapidly becoming the second most frequent pathologic diagnosis at pelvic laparotomy. The chief complaints which cause any woman to consult a physician are pelvic pain, bleeding dysfunction, dysmenorrhea and sterility. In each of these categories endometriosis must be given serious consideration either as the cause of, or as a contributory factor to, the disability. Pelvic pain that has a definite relationship to the approaching menstruation and a typical dysmenorrhea are cardinal points in the diagnosis of endometriosis. In 45 per cent of cases of endometriosis there is primary sterility and in another 15 per cent there is secondary sterility of ten or more years' duration.—Virgil S. Counseller, M.D., and Fletcher S. Sluder, Jr., M.D.; Rochester, Minn.; Rocky Mtn. Med. Jr., Vol. 42, No. 3, March, 1945.



# Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

## A SPOT ON THE LUNG

It is futile to search in dictionaries or medical text-books for a definition of the term "a spot on the lung". But the term is being used with great frequency by physicians, nurses and laymen alike. If this term is subjected to scrutiny, it is found that it may mean anything and everything that produces either a shadow or an area of decreased density in a chest roentgenogram or anything and everything that causes abnormal physical signs over the lungs. If, then, this expression has no meaning that cannot be stated more precisely in other terms, it remains to be found out why it is being used. If this is one of the terms that does not express a definite meaning, does it possibly obscure a meaning?

Nobody who has searchingly studied the histories of patients with pulmonary disease can doubt that the real function of the phrase, "a spot on the lung," is to cloud the facts. It is a cloak for a great variety of pulmonary diseases, a protective screen for the inability or unwillingness of a physician to arrive at a diagnosis acceptable to himself, a disguise for a bitter truth that the physician hesitates to tell the patient, an escape for the patient who tries to elude further diagnostic work and necessary treatment. After all, one does not die of "a spot on the lung," but one can die of bronchial carcinoma and one might die of pulmonary tuberculosis. Along with much other evasive, medical double-talk, "a spot on the lung" is a verbal mechanism of escape from reality. In the same category belongs the term "a touch of tuberculosis" and, improperly applied, "nothing but a little thickened pleura".

No physician needs to be told that "a spot on the lung" is no diagnosis. He realizes that it is evidence, on the one hand, of healed disease which calls neither for treatment nor for alarming its bearer, or, on the other, of active disease in need of treatment. The physician sometimes uses the term in patients in whom he has failed to establish, with a certainty that carries conviction for himself, the difference between active disease and obsolete scar. "A spot on the lung" has a pleasantly innocent sound. It lulls into inertia and indifference whatever doubts or curiosity the patient, and, even in some cases, the doctor may have. But still it is, for the physician, a mental reservation. It seems to beckon as a safe place to stand if "a spot on the lung" later turns out to be carcinoma, tuberculosis or bronchiectasis.

Admittedly, this judgment may be harsh. But

I dare say that it will be resented only by those who, with the instrumentality of this ambiguous term, neglect their obligation of persevering until "a spot on the lung" has been accurately diagnosed. No person need be told that he has "a spot on the lung". If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculous infection—one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginnings of destructive disease, it is, in other cases, the starting point for tuberculophobia and anxiety neuroses, conditions that are no less crippling and hardly more easily curable than tuberculosis itself.

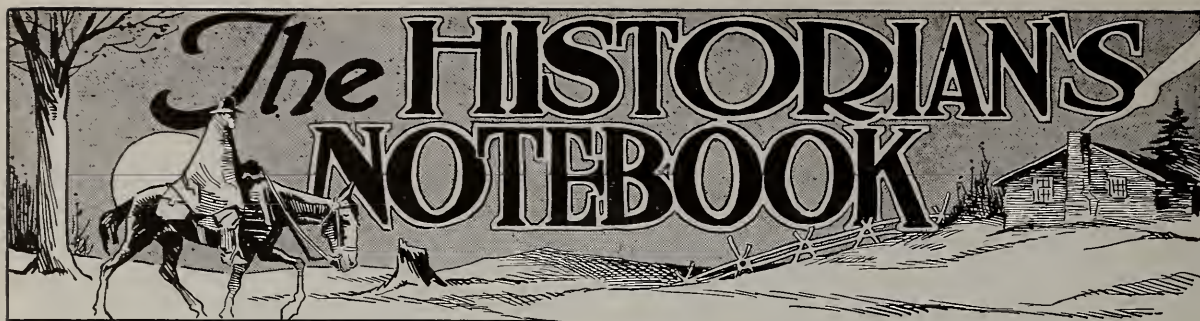
But, though every reflecting physician knows that "a spot on the lung" is a meaningless and dangerous term, the utter convenience of the expression—and others like it—mitigates against their prompt extinction. Past experience justifies a pessimistic outlook. No amount and intensity of medical education are likely to eliminate entirely the term from medical parlance.

Medical education however is being overtaken by the information that the public, including the prospective patient, is acquiring. People are learning to realize fully the confusing ambiguity of the term, they are beginning to refuse its acceptance just as an enlightened consumer protests against ambiguous and misleading labels on packaged goods. And the comparison is eminently proper: for all intents and purposes, "a spot on the lung" is ambiguous and misleading labeling. It may well be that through the protest of the consumer, by the refusal of every layman to be satisfied with the pseudo-diagnosis of "a spot on the lung" the term will eventually disappear.

It is high time for the medical and nursing professions and everyone engaged in tuberculosis work to bury a medical term that has quite literally buried so many patients.—A Spot on the Lung, Max Pinner, M.D., The NTA Bulletin, January, 1945.

Recent investigations have centered more upon the toxic effects of thiouracil, especially as it affects the hemopoietic system. There have been seven known deaths due to agranulocytosis and leukopenia attributed to this method of treatment.—Frederic Gerard Burke, M.D., Washington, D.C.; Med. Annals of D.C., Vol. XIV, No. 3, March, 1945.





Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## "The Medical Pioneer—His Ills, Cures, and Doctors"

A REVIEW BY JONATHAN FORMAN, B.A., M.D.

AT the time of the celebration in Columbus of the one-hundredth anniversary of the founding of the Medical College at the Willoughby University of Lake Erie (1834-1934), a group of those who are interested in local medical history began cooperative work in this field. First there appeared a source book in which was chronicled the story of the College of Medicine of the Ohio State University and its predecessors, together with the acts of the legislature, charters, contracts, deeds and gifts, and biographical sketches of all whose names had appeared on the faculty rolls. Late that year, this department of *The Journal* began.

Historical sketches followed in the published volumes of the Annual Post-Collegiate Assemblies of the Medical Alumni of the College of Medicine of the Ohio State University. Shortly thereafter, one issue each year of *The Ohio Archaeological and Historical Quarterly* began to be devoted to papers from the pens of this same group. All in all, nearly two hundred books and papers dealing with local medical history have appeared under the authorship of this cooperating group of students of Ohio's early history. No doubt each of the writers secretly hoped that somehow he would find sufficient time to make a correct interpretation of all the material that was thus being assembled and publish it in book form.

The plans of the group, however, call for all to go on assembling facts and chronicling the story of this and that epidemic, the details of the life of this and that outstanding physician, and history of one medical organization after another. There is so much to do and so little time in which to do it.

It is with the greatest pleasure then that this group has welcomed a new book entitled "The Midwest Pioneer, His Ills, Cures, and Doctors" (R. E. Banta, Crawfordsville, Indiana—\$5.00). This volume is the by-product of more extensive work in the field of Middle-West history under-

taken by Madge E. Pickard and R. Carlyle Buley of the University of Indiana. In these days of poor book design and haphazard printing, it is a delight just to take this volume in one's hand, to say nothing of the enjoyment of perusing it. Appropriately designed, perfectly printed on rag-content paper that appeals to the touch, the total product adds much to the library of any lover of books.

The content justifies the book's splendid appearance. The story of pioneer medicine is told in a straightforward, non-technical manner that makes for easy and interesting reading. The book has been divided into seven chapters: "He's Ailin'"; "Home Remedies"; "Doctors: Blood, Blister, and Purge"; "The People's Doctors"; "Medical Aids"; "Who Is A Doctor?"; "Drugs and Patents".

Few of us have adequate knowledge of the pioneer folk in Ohio and their sicknesses. Whole villages were wiped out by fevers in epidemic form, by malaria, smallpox or diphtheria. The pioneers' exposure to weather, their use of bad liquor, their ignorance and carelessness made them easy victims of one sickness after another. As these authors expressed the situation in their first chapter, "When pioneers met, it was more than mere courtesy which called forth the inquiry concerning the health of families and acquaintances. . . . Were no serious illnesses present, the answer would be 'Tolerable, just tolerable'. Things seldom got better than that".

Provided a doctor were available, it required time and money to get his services and he was, generally speaking, called only for very serious cases. Even then, home remedies or folk cures were likely to be used before the doctor was called—and maybe after he left. Besides being responsible for the domestic economy of the home—everything from food and clothing to spelling and courting—the mother, the wife, the woman of the house by prerogative and default was the instructress of medicine and administra-



trix of treatments. If home remedies did not suffice, there was usually some one in each community who was handy in caring for the sick and was steeped in his or her lore or system of cures—a combination of homemade science, experience and superstition.

So the authors have gathered into some sixty interesting pages the folk lore and the superstitions of the pioneer and his leaders. Regular medicine, too, in those days was empiric. As in politics and religion, in matters of healing one man's experience was as good as another's and even better if the experience happened to be his own. If doubt arose, fears could be allayed by resorting to a "Family Doctor Book" which most pioneer families owned and frequently consulted.

These authors have related the story of the country doctor in pioneer days with his bleeding, blistering and purging. "Though frequently short of learning, intolerant of rivals, and given to petty quarrels, he was abundantly possessed of those qualities which made him usually a figure at the same time feared, loved and venerated."

In their third chapter the authors set forth the story of these doctors in an age of individualism, their education, their equipment, their beliefs, and their labors. Early dentistry and the beginning of formal dental education at Bainbridge, Ohio, as established through the research of Edwards Mills, D.D.S., the scholarly editor of the *Ohio Dental Journal*, are well summarized.

The pioneer days, marked by individualism and the actual competency of each man to choose his politics, his religion, and his own poison, opened the way for many bizarre ideas to attach themselves to, and operate within, the field of medicine. As Dr. Shyrock has pointed out, these ideas all follow one formula, i.e.: The greatest discoverer, the master mind, who unearthed the truth—the single and easily comprehended cause of disease, a straightforward cure, all set forth in an infallible book, the gospel of the cult. Over this formula, multiplied in these pioneer days, came Thomsonianism, the Reformed Botanic System, Eclecticism, Homeopathy, Chromotherapy, Grahamism, Hydrotherapy, Vitapathy and a dozen other vigorous cults. All flourished until Virchow described the microscopical anatomy of disease and his students had established germs as the cause of infectious diseases.

As the country became settled and Ohio moved up to become one of the leading states in population, society began to stabilize itself. It was then the question arose—Who is a doctor? At first a "doctor" was one who called himself such. This made all those who possessed an M.D. degree very jealous of that distinction. As

a matter of fact, the medical profession made a serious error in public relations when it became sufficiently careless to print cards and signs Dr. ...., instead of ..... M.D.

"In agriculture, the American accepted improvement in machinery first and easiest; these saved labor. Next came improvements in animals; they saved dollars. Last and hardest to the farmer came general science—soil chemistry, diets, plant pathology—the 'book-larnin' of the 'printer farmers'. So it was in medicine. The first to receive popular acceptance were the manual services of the profession: setting of broken bones, amputations and the like, especially after the advent of anesthesia. Second, came more reliance upon the physician in cases of contagious disease. Many persons who would not call a doctor for croup, dysentery, or rheumatism would do so for smallpox, diphtheria or even measles. Last—and this after the pioneer period—came acceptance of the germ theory, vaccines, hospitals and preventive medicine. Medicine, as compared with applied science in mechanics, was at a disadvantage. Advances in general education at times seemed to make the people more critical of the doctors, who themselves were critical of each other." Thus we move from the early times when healers were self-appointed doctors to the period of the bona fide Doctor of Medicine.

The rise of the drug trade paralleled the development of medicine in the western country and with it, paralleling the development of a press receptive to advertising, arose the patent medicine industry. "During the period between home-made medicine and the rise of the American pharmaceutical manufactories, the United States depended largely upon Europe for its drugs. Philadelphia, the American medical center, was the chief importer. Many of the earlier physicians went more and more into the drug business and gave up their practice of this more lucrative pursuit." Such were Dr. G. Dauson of Pittsburgh, Dr. Lincoln Goodale of Columbus. Daniel Drake also at one time had a drug store in Cincinnati.

Because the pioneer spirit persisted, the American citizen has reserved the sovereign right to try to "make the science of medicine conform to his conception of democracy, to organize, complain, refuse to regulate, do his own doctoring or none at all." Yet, in spite of everything, most survived.

Pickard and Buley have filled in their outline with three hundred and forty pages of fascinating detail. It all adds up to a volume so beautiful and attractive that there ought to be enough Ohio physicians to buy up at once the whole limited edition of 500 copies of this charming and valuable contribution to the history of medicine.

## The Office Diagnosis of Early Cancer

—ARTICLE No. 2 OF A SERIES

**EDITOR'S NOTE:** The accompanying article was prepared by the Committee on Public Health Education of the Ohio State Medical Association by direction of The Council.

It is one of several articles appearing in *The Journal*, addressed especially to physicians with the hope that they will elicit greater interest in the cancer problem and encourage the early diagnosis of malignant disease while it is still curable.

Publication of these articles is part of the Ohio State Medical Association's program of cooperation with the Ohio Field Army, American Cancer Society, in education of the public and members of the medical profession on the subject of cancer control.

The first article was published in the February issue of *The Journal*. Additional articles will be presented in subsequent issues.

**N**O diagnosis of cancer is complete without a pathological report. Many diagnoses can only be made with the help of roentgenological or other laboratory studies. However, the general practitioner, in his own office, with the help of the instruments he uses every day, may detect many suspicious lesions and start the patient toward a final diagnosis.

### WHAT YOU CAN SEE:

1. With the help of a pocket flashlight, a tongue depressor and a finger cot, the physician can detect early precancerous or malignant changes of the roof or floor of the mouth, of the tongue, cheek or tonsil.

2. A vaginal speculum and a good light will disclose lesions of the cervix and vagina.

3. A proctoscope will reveal a high percentage of the early malignant lesions of the rectum.

4. Careful observation, with a comparison of the two breasts, will reveal the elevated or retracted nipple, or the "dimpling" of the skin which are so frequently associated with malignant tumors. Any discharge from the nipple, clear, serosanguineous, or bloody, is a signal for further study. The elevation or distortion of the breast contour is a symptom which should not be ignored.

5. Thickened or scaly skin may suggest cancer as strongly as the persistent ulcerating sore.

### WHAT YOU CAN HEAR:

1. Persistent hoarseness may indicate cancer of the larynx.

2. Unexplained cough might mean cancer of the lung.

### WHAT YOU CAN FEEL:

1. Careful, systematic palpation of the breast will reveal many early lesions. Most lumps in the breast are not cancer, but since many of them are, ALL lumps should be investigated. The painless lump is the dangerous lump.

2. A high percentage of the early rectal cancers are within reach of the palpating finger. The routine use of the gloved finger will change many diagnoses from "hemorrhoids" to "cancer" and give the patient a reasonable hope of a prolongation of life.

3. In the male, the rectal examination should include an examination of the prostate. A hardened, nodular prostate should be viewed with suspicion.

4. Bimanual vaginal examination will give the clue to lesions of the cervix, of the fundus, ovary and tube.

5. Enlarged lymph nodes—axillary, cervical, supraclavicular, or inguinal—are readily palpated and are significant. They may be evidence of metastatic cancer, or of primary malignant disease of the lymphoid system.

6. Malignant growths within the abdomen or pelvis can frequently be detected by deep palpation.

### CANCER DIAGNOSIS REQUIRES TEAM WORK:

Don't forget the importance of biopsy. Remember that the correct choice of site for biopsy, the adequacy of the specimen, and its freedom from mechanical distortion are factors which are essential to a correct pathological diagnosis. Don't overlook the contribution which can be made by the skilled roentgenologist. Don't hesitate to ask for a consultation in the presence of the unexplained symptom.



# Proceedings of The Council

## Additional Recommendations Regarding Medical Indemnity Company Approved; Action on Legislative Proposals

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, March 25, 1945, with the following in attendance: Past-President Sherburne, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Rutledge, Lincke, Swan, Micklethwaite, Harding, and Knoble; Dr. Rothenberg, Chairman of the Committee on Medical Service Plans; Mr. Stichter, legal counsel; Executive Secretary Nelson and Assistant Executive Secretary Saville.

In the absence of Dr. Schriver and Dr. McNamee, Dr. Sherburne, Past-President, presided.

On motion by Dr. Noble, seconded by Dr. Micklethwaite, and carried, the minutes of the last meeting of The Council held on January 14, 1945, were approved.

The Executive Secretary reported that membership in the State Association as of March 24, 1945, totaled 6,540, of which 1,958 were military members; compared to a total membership of 6,878 on December 31, 1944.

### MEDICAL INDEMNITY PROJECT

Dr. Rothenberg, chairman of the Committee on Medical Service Plans, presented a report from his committee consisting of suggested Articles of Incorporation and Regulations relating to the organization of a medical indemnity company under the Ohio insurance laws. Following a lengthy discussion and a section by section analysis of the documents, The Council, on motion by Dr. Knoble, seconded by Dr. Swartz, and carried by a unanimous vote, approved the recommendations of the committee in principle and in substance, subject to minor revisions in wording by Mr. Stichter after further conference with the legal counsel for the Ohio Blue Cross Plans, and authorized the filing of the Articles of Incorporation with the Secretary of State at the appropriate time. The motion which was adopted also authorized the appropriation of an amount of \$35,000.00 from the unassigned funds of the State Association to be used, if necessary, as part of funds needed in the financing of the corporation.

On motion by Dr. Swartz, seconded by Dr. Dixon, and carried, The Council expressed appreciation to the Committee on Medical Service Plans for the excellent work which it has done to date, and authorized the committee to work out arrangements and details for the sale of stock to the amount of \$100,000.00 required by law in the organization of the indemnity company.

On motion by Dr. Lincke, seconded by Dr. Micklethwaite, and carried, the President was empowered to name the incorporators.

On motion by Dr. Lincke, seconded by Dr. LeFever, and carried, The Council approved the arrangements which had been made by the committee for a conference with representatives of the Cleveland Hospital Service Association on this matter, scheduled for April 6.

### RURAL HEALTH CONFERENCE

A report of a conference held in the Headquarters Office of the Ohio State Medical Association on February 4, attended by representatives of the Committee on Medical Service Plans and representatives of the Ohio Farm Bureau, the Ohio Grange and the Ohio Land-Use Planning Committee, was presented for consideration. At that conference questions of rural health and medical services were discussed at length.

At the suggestion of representatives of the farm groups who attended the February 4 conference, The Council was requested to consider the desirability and feasibility of amending the Ohio Enabling Act for Medical Service Plans, especially with respect to the elimination of the income limitation; elimination of the requirement that at least 10 physicians in the county must participate; and elimination of the requirement that 51 per cent of the physicians in any county or part thereof must be participating physicians.

After considerable discussion, on motion by Dr. Knoble, seconded by Dr. Messenger, and carried unanimously, The Council adopted the following statement on this matter:

"It is the sense of The Council of the Ohio State Medical Association that no changes should be made at this time in the Ohio Enabling Act for Medical Service Plans. The Council feels that the present provisions of the act are sound; that the act sets up the proper legal foundation for inauguration of medical service plans for persons of low income, for which purpose it was designed; and that wartime conditions rather than any provisions of the act itself are the reasons why no medical service plan is in operation in Ohio at this time."

### SURVEY OF RURAL HEALTH SERVICES PROPOSED

Another suggestion offered by the conferees was that The Council consider the advisability and feasibility of organizing an unofficial voluntary committee to study rural health and medical problems. The Council was advised that the executive board of the Ohio Farm Bureau had

approved such a project in principle, subsequent to the February 4 meeting.

After a full discussion of this question The Council, on motion by Dr. Rutledge, seconded by Dr. Swartz, and carried, adopted the following statement on this matter:

"Realizing that improvements are necessary in medical and health services for the residents of Ohio residing in rural and farming areas of the state, The Council of the Ohio State Medical Association favors the creation of a voluntary, unofficial committee to make a survey of health needs and facilities throughout rural Ohio.

"The Council authorizes participation of the Ohio State Medical Association in this project, providing:

"1. Such survey is confined to rural areas.

"2. The study committee consists only of representatives of organizations directly concerned with the problem of rural health services, namely: Representatives of the Ohio Farm Bureau, Ohio State Grange, Ohio State Medical Association, Ohio State Dental Society, and the Ohio Hospital Association.

"Amplifying the above, The Council recommends that:

"1. Two representatives shall be selected by each of the five organizations mentioned above as members of the study committee.

"2. The following shall be designated as ex-officio members of the committee, without vote, to serve in a consulting capacity: the State Director of Health, the president or the secretary of the Ohio Federation of Public Health Officials, the dean of the College of Agriculture, Ohio State University, the dean of the College of Veterinary Medicine, Ohio State University, the chairman of the Sub-Committee on Health of the Ohio Land-Use Planning Committee or some member of that committee designated by the chairman to represent him, and others, to be designated from time to time by the study committee, representing other organizations and agencies which the committee may feel can assist it in its undertaking.

"3. The Department of Rural Economics and Rural Sociology, Ohio State University, shall be requested to assist on details and technical matters relating to the survey.

"4. Recommendations made by the study committee shall be subject to review by the official board of each of the five organizations represented on the committee and any recommendations made by the committee shall not become the official action of the committee unless approved by a majority of such organizations.

"5. Efforts shall be made to obtain adequate funds from some philanthropic or educational organization or foundation for the expenses of the study. If this is not feasible, consideration shall be given by the organizations sponsoring the study to financing the committee's activities on a pro rata or some other equitable basis."

#### LEGISLATION

The Executive Secretary reviewed for The Council pending state and Federal legislation of interest to the medical profession and on matters involving public health.

A communication from Dr. Charles A. Doan, dean of the College of Medicine, Ohio State University, and Dr. Russel G. Means, chairman of the Alumni and Public Relations Committee, College of Medicine, Ohio State University, was considered. The communication requested the Ohio State Medical Association to support the request of the College of Medicine and the College of Dentistry, Ohio State University, for funds for improvement and expansion of the facilities of the medical and dental colleges and their auxiliary units.

On motion by Dr. Brindley, seconded by Dr. Dixon, and carried, The Council adopted unanimously the following statement of policy on this question:

"Among the important proposals which will be considered by the Ninety-Sixth Ohio General Assembly now in session will be a request for funds to be used by the Ohio State University for the improvement and expansion of the facilities of the College of Medicine and College of Dentistry and their auxiliary units.

"The Council of the Ohio State Medical Association wishes to endorse this proposed program in principle, recommending that the medical profession of the state give its active support to the project and, further, recommending that the General Assembly provide funds sufficient to carry out the essential purposes of the program.

"The Council is not in a position to judge as to the exact amount of money which may be necessary for this postwar expansion program. That is a question which must be answered by the General Assembly, based on carefully prepared data which will be submitted to it by University officials and the postwar improvement committee representing the two colleges."

On motion by Dr. Rutledge, seconded by Dr. Dixon, and carried, The Council referred a communication from the Cincinnati Cancer Control Council, asking the attitude of the Ohio State Medical Association on Senate Bill 228 to provide a cancer study commission, to the Committee on Public Relations and Economics for study and action.

The Council then considered S. 637, pending in the Congress, to authorize the deferment under Selective Service of a specific number of pre-medical and medical students in order to prevent the threatened shortage of medical students. On motion by Dr. Harding, seconded by Dr. Dixon, and carried, The Council approved the proposed legislation.

There was a discussion of S. 191, introduced by U. S. Senator Harold H. Burton, Ohio, and U. S. Senator Lister Hill, Alabama, to provide Federal funds to be allocated to states for the construction of hospitals and public health centers. On motion by Dr. Swartz, seconded by Dr.



Rutledge, and carried, the Burton-Hill Bill was approved in principle.

#### CRIPPLED CHILDREN DIRECTIVE

The Council reconsidered its action of January 14 regarding a directive of the Children's Bureau of the U. S. Department of Labor, effective July 1, 1945, relating to the crippled children's program, there having been some misunderstanding and a need for clarification of the action taken on this matter.

On motion by Dr. LeFever, seconded by Dr. Knoble, and carried, The Council adopted the following clarifying supplemental statement on this question:

"1. The Council is not opposed to the operation of proper diagnostic clinics for crippled children, providing referral of the child to such diagnostic clinic or hospital for diagnostic purposes is made by the attending or family physician of such crippled child. The Council does object to the referral of a child by anyone other than the attending or family physician.

"2. No child should be provided with treatment under the Crippled Children's Program unless the parents or guardian of the child are financially unable to provide such child with necessary care and treatment. This policy would not apply to diagnostic procedures as proper diagnosis must serve as a basis for determining whether or not the child is eligible for care under the Crippled Children's Program and whether or not the parents or guardian would be financially able to pay for necessary treatment services."

#### MEMBERSHIP DUES

On motion by Dr. Rutledge, seconded by Dr. Dixon, and carried, The Council adopted the following statement, supplementing the existing policy on waiver of Ohio State Medical Association dues:

"Upon the written endorsement of the secretary of the county medical society of which he is a member that he is unable to engage in the private practice of medicine because of service-connected disabilities, a discharged Ohio medical officer may be carried on the membership roster of the Ohio State Medical Association without the payment of State Association dues until such time as, in the opinion of the county medical society of which he is a member, he is able to resume the active practice of medicine.

"Upon the written endorsement of the secretary of the county medical society of which he is a member, an honorably discharged Ohio medical officer who enters postgraduate or refresher training may be carried on the membership roster of the Ohio State Medical Association without the payment of State Association dues during the period of such postgraduate or refresher training."

#### CHEST SURVEYS

A communication from the Ohio Radiological Society, recommending that the Ohio State Medical Association take favorable action on the principle of mass chest surveys for public health

purposes and suggesting certain basic principles which should be followed in the conduct of such surveys, was considered.

On motion by Dr. Brindley, seconded by Dr. Dixon, and carried, The Council adopted the following resolution on this matter:

"The Ohio State Medical Association approves the principle of mass chest surveys for the detection of pulmonary tuberculosis for public health purposes, providing such surveys are conducted in line with the following principles:

"1. Agencies conducting such surveys should seek and receive the approval of the county medical society in the community concerned which should appoint a committee to act as a consultative and advisory body to the surveying agency.

"2. The films should be examined by physicians who are trained and competent to interpret radiographs of the chest.

"3. Cases showing abnormalities should be immediately referred for further study and care to local physicians, or, when this is impractical, to other available agencies.

"4. The question of fees for roentgen interpretation of films in surveys for public health purposes should be determined locally."

#### TREASURER PRO TEM ELECTED

Dr. Sherburne informed The Council that Dr. LeFever, a member of the Medical Corps, Navy Reserve, had received orders to report to active duty in the near future. On motion by Dr. Brindley, seconded by Dr. Micklethwaite, and carried, The Council expressed to Dr. LeFever its very best wishes and appreciation for the splendid services he has rendered the State Association, granted him a leave of absence, and elected Dr. John Mitchell, Columbus, as treasurer pro tem of the Ohio State Medical Association, effective when Dr. LeFever reports for military service.

#### MISCELLANEOUS

A communication from a county medical society, requesting the Ohio State Medical Association to ask the Ohio Director of Health to provide for Wassermann tests for syphilis in the State Laboratory on specific request of a physician sending in the blood, was considered. Information obtained from the Director of Health, to the effect that the State Laboratory follows the procedure of providing only Kline and Kahn tests and advising that it would not be feasible for the laboratory because of the large number of tests made annually to provide other kinds of tests, even on request, was presented to The Council. On motion by Dr. Brindley, seconded by Dr. Lincke, and carried, The Council expressed the view that it would not be feasible for the State Laboratory to make tests other than those which are done routinely and that where a physician feels that some specific test, other than those done routinely by the State Laboratory,

is necessary, the physician should arrange with some private or local public health laboratory for the specific test desired.

A letter from Dr. H. H. Skinner, chairman of the Maternal and Child Welfare Committee of the Washington State Medical Society, was read. Dr. Skinner requested the Ohio State Medical Association to make a poll of all Ohio physicians handling cases under the Emergency Maternity and Infant Care Program of the U. S. Children's Bureau and to take favorable action on a suggestion that the application for maternity care be amended so that the applicant could supplement from her own funds payment made to the attending physician under the EMIC Program. On motion by Dr. Brindley, seconded by Dr. Micklethwaite, and carried, the previous policy of the Ohio State Medical Association on the EMIC Program was reaffirmed and no action on the suggestion made by Dr. Skinner was authorized, it being the sense of The Council that such action would be in effect a compromise with the principles expressed in the original action of The Council on the EMIC Program.

The Council was advised that a labor newspaper, which has been carrying editorials in opposition to the Wagner-Murray-Dingell Bill, has been soliciting individual physicians for contributions. On motion by Dr. Dixon, seconded by Dr. Swartz, and carried, The Council expressed itself as believing that it is not the function of the Ohio State Medical Association to take official action on commercial projects of this kind and that whether or not a physician cares to make contributions is a matter for him to decide as an individual.

A request from the Cleveland Institute for Medical Secretaries, that the Ohio State Medical Association approve its activities and training course, was considered. On motion by Dr. Knoble, seconded by Dr. Swartz, and carried, The Council expressed itself as believing that this matter is not a medical or health question and that, therefore, no action by the Ohio State Medical Association is indicated.

On motion by Dr. Dixon, seconded by Dr. Lincke, and carried, The Council expressed sincere regret to learn of the death of Dr. J. S. Rardin, Portsmouth, a former President of the Ohio State Medical Association, and instructed the Executive Secretary to write a suitable communication to Dr. Rardin's daughter.

A communication from the Columbus Academy of Medicine, setting forth amendments to the constitution and by-laws of that society adopted recently by the Academy, was considered and, on motion by Dr. Brindley, seconded by Dr. Micklethwaite and carried, the amendments were approved.

The amendments recently adopted by the Cleveland Academy of Medicine to its constitution

and by-laws, and reviewed by the chairman of the Judicial and Professional Relations Committee, Dr. John A. Caldwell, Cincinnati, were considered and, on motion by Dr. Brindley, seconded by Dr. Knoble, and carried, were approved.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,  
*Executive Secretary.*

### Dr. McCann, Youngstown, Appointed To State Medical Board

Dr. John N. McCann, Youngstown, has been appointed by Governor Frank J. Lausche to membership on the State Medical Board, for a seven-year term, ending March 18, 1952. He succeeds Dr. John H. Skavlem, Cincinnati, who was appointed last November to fill the unexpired term of the late Dr. Claude V. Davis, Pennsville. Dr. Skavlem requested that he not be considered for reappointment because of his extensive activities on the teaching staff at the University of Cincinnati, in private practice and in civic affairs.



DR. McCANN

A native of Youngstown, Dr. McCann, has specialized in internal medicine there for over 15 years. He is a graduate of the University of Georgetown, Washington, D.C., having received the Bachelor of Science and Doctor of Medicine degrees in 1927, and is on the Senior Medical Service and Cardiology Service of St. Elizabeth's Hospital, Youngstown, and a member of the Board of Trustees of the Mahoning County Tuberculosis Sanitarium.

Dr. McCann was one of the speakers on the Ohio State Medical Association's Regional Postgraduate Lecture Series in 1940, and was a delegate from the Mahoning County Medical Society at the Annual Meetings of the State Association in 1942 and 1943. He is a fellow of the American Medical Association.

Dr. Edward J. McCormick, Toledo, a Past-President of the Ohio State Medical Association and member of the Council on Medical Service and Public Relations of the American Medical Association, addressed a joint meeting of the Wayne County Medical Society and the Woman's Auxiliary, April 16, at the Detroit Institute of Arts. His subject was: "Medicine—What Does the Future Hold?"



# Revised Medical and Surgical Fee Schedule Adopted by Ohio Industrial Commission, Effective on May 1

**A** REVISED Medical and Surgical Fee Schedule has been adopted by the Ohio Industrial Commission, effective May 1.

Physicians rendering services to Workmen's Compensation claimants on and after May 1 should bill the Commission in accordance with the new fee schedule.

Printed copies of the new schedule and the recodified rules and regulations applying to physicians, nurses, dentists and hospitals are being mailed to all members of the Ohio State Medical Association. Physicians who fail to receive one of these pamphlets or who need additional copies may obtain them from the Commission's offices, State Office Building, Columbus 15, Ohio.

## SERIES OF CONFERENCES HELD

This general revision of the Medical and Surgical Fee Schedule (including fees for nurses and dentists) was made by the Commission after a series of conferences with the Committee on Workmen's Compensation of the Ohio State Medical Association and a similar committee of the Ohio State Dental Society.

Following these conferences, the Committee on Workmen's Compensation of the Ohio State Medical Association submitted its recommendations to The Council of the Association and these recommendations, with the endorsement of The Council, were then submitted to the Commission for its consideration.

## MANY SUGGESTIONS ADOPTED

Most of the changes suggested by The Council of the Ohio State Medical Association were adopted by the Commission. A few recommendations made by the Association were not adopted. However, additional conferences between representatives of the Association and the Commission will be held for the purpose of giving further consideration to those matters on which there was disagreement and for the purpose of discussing a number of questions of general administrative policy which could not be covered in the series of conferences held during the Summer and Fall of 1944.

## COMPARISON OF OLD, NEW SCHEDULES

Comparison of the new Medical and Surgical Fee Schedule with the one previously in effect (many of the fees had been in effect since 1926) reveals:

- Increases in the fees for 62 procedures;
- Addition of 68 procedures, with specific fees, to the schedule;
- No changes in 68 items in the schedule;
- Decreases in the fees for seven procedures.

Space will not permit a detailed review of the new schedule and of the revised Rules and Regulations, but some of the outstanding and important changes are as follows:

1. The Rules and Regulations were recodified. Wording was changed in some instances for the purpose of clarification and amplification. For the first time, all Rules and Regulations used by the Commission in the adjudication of medical, dental, nursing and hospital bills are set forth in printed form in the Fee Schedule pamphlet.

2. A new rule on physiotherapy was inserted, reading as follows: "Fees for physiotherapy will not be approved for more than 10 treatments unless authorized. The nature of the disability must clearly indicate the necessity for such treatments. Fees for physiotherapy in cases covered by a flat fee will not be approved without authorization. Physiotherapy shall include manipulation, massage and all types of thermal, electrical and hydrotherapy." Under the old physiotherapy rule fees for such treatment were not allowed unless treatment was authorized in advance by the Commission. The new rule permits up to 10 such treatments without authorization.

## IMPORTANT INCREASES

3. The period of after-care covered by a flat fee in surgical procedures, dislocations, fractures, amputations and ophthalmological procedures was reduced from 90 days to 60 days. This means additional fees may be paid for services in extended cases — services required after 60 days.

A period of three weeks was established as the period covered by the flat fee in ear, nose and throat surgical procedures.

4. The fee for treatment at office after the first treatment was increased from \$1.50 to \$2.00 and the fee for treatment at hospital after the first treatment was increased from \$2.00 to \$2.50.

5. Small increases have been made in a number of miscellaneous procedures by allowing a fee for the regular office, hospital or home visit in addition to the fee for the specific procedure. Examples: Suturing lacerations and intravenous medication.

6. Mileage outside corporation limits was increased from 25 cents to 50 cents per mile one way.

## MORE INCREASES MADE

7. Fees were increased in 11 surgical procedures, in six items involving dislocations, in 17 procedures involving fractures, in five types of

amputations, for five ophthalmological procedures; for two ear, nose and throat procedures; and for three X-ray items.

8. The fee for administration of anesthesia in prolonged operations was increased. Under the new schedule, the anesthetist is allowed a fee of \$10.00 for the first 30 minutes or fraction thereof and an additional \$5.00 for each succeeding 30 minutes or fraction thereof. The old fee was \$10.00 regardless of the time consumed by the operation.

9. A new item was inserted in the schedule, providing a fee of \$3.00 for affidavits furnished by the physician upon request of the Commission and containing information used as a basis for adjudication of the claim.

#### NEW SECTION ADDED

10. An entirely new section was inserted in the schedule, entitled "Reconstructive Surgery". Such cases (mostly difficult orthopedic and reconstructive surgical cases) must have the authorization of the Commission. The schedule provides for six months' after-care under a flat fee which includes the cost of first cast. However, a fee amounting to fifty per cent of the established fee for casts will be allowed for application of subsequent casts. The fees established are comparable in most instances to recommendations presented to the Workmen's Compensation Committee of the State Association by specialists in orthopedics and reconstructive surgery.

11. Decreases authorized by the Commission included the fees for injection of antitetanic serum, serological examination of blood for syphilis, blood count, and urinalysis. These reductions were not approved by the State Medical Association. On the other hand, the Commission felt that such reductions were justified because of the reduction in the costs of materials used in some of the procedures and in the light of the present average laboratory charges in cases other than Workmen's Compensation cases.

#### MUST USE PRIVATE LABORATORIES

An important provision was inserted in the schedule with respect to serological examinations. It provides that the fee for serological examination (\$2.00 plus regular treatment fee) will not be allowed if the laboratory test is made in a laboratory supported by public funds. The effect of this rule will be that the physician must make use of the facilities of a private laboratory if he expects to receive a fee for office visit and the drawing of the blood.

As already stated, both the Commission and the Workmen's Compensation Committee of the Ohio State Medical Association have agreed to hold frequent conferences for the purpose of

reviewing questions which may arise in the administration of the new fee schedule. If readjustments are found necessary, based on experience, the Commission has indicated its desire to consider additional recommendations which may be made by the Association's committee.

### State Medical Board Upheld

The State Medical Board has not the implied or cognate power to restore a license after revocation, the Ohio State Supreme Court decided April 4, in refusing to issue a writ of mandamus against the Board in the case of *The State, ex rel. Welsh v. State Medical Board of Ohio et al.*, No. 30167, (145 O.S.).

The relator obtained a license on January 4, 1916, to practice hydrotherapy, a limited branch of medicine and surgery. His license was revoked by the State Medical Board and he appealed to the Common Pleas Court of Cuyahoga County, which court dismissed his appeal. Relator applied for a reinstatement of his license and the Board refused his request, but advised him that he would be permitted to take an examination for a license to practice hydrotherapy under the present rules and regulations of the State Medical Board.

Counsel for the relator admitted that the Legislature failed expressly to endow the Medical Board with the powers of restitution of license after revocation, but contended that the Board has the implied or cognate power to do so. The Court held that a writ of mandamus will not issue to command performance of "implied or cognate power", citing Section 12283, General Code, which defines mandamus as "a writ issued . . . to . . . a . . . board . . . commanding the performance of an act which the law specially enjoins as a duty resulting from an office. . . .".

### Youngstown Postgraduate Program

The 17th Annual Postgraduate Assembly of the Mahoning County Medical Society was held at the Pick-Ohio Hotel, Youngstown, April 11, with a group of physicians from the Marquette University School of Medicine, Milwaukee, presenting the program. In the morning, Dr. Francis D. Murphy and Dr. Joseph F. Kuzma held a clinical pathological conference at the South Unit, Youngstown Hospital, and Dr. Carl Eberbach conducted a surgical clinic at St. Elizabeth Hospital. Addresses in the afternoon were: "Present Trends in Hemorrhagic Diseases", Dr. Fred Madison; "Treatment of Biliary Tract Diseases", Dr. Eberbach; "Diagnosis and Treatment of Nephritis", Dr. Murphy. At the dinner session, Dr. Eben Carey, Dean of Marquette University School of Medicine, spoke on "The Future of Medicine".





"SINCE many of the conditions obtaining among troops during war time are simultaneously factors which predispose to the endemic and epidemic spread of . . . amebic dysentery among military personnel and civilians . . . these diseases assume great significance . . . not only to the medical departments of the armed forces but to the civilian physician as well."

—Lt. Com. W. L. Voegtlin, USNR: N.W. Med., 43:69 (1944)



Increased investigation into "tropical diseases" has disclosed the unsuspected prevalence of amebic dysentery in the United States.

In suspected or frank cases, and for the treatment of "carriers,"

# *Diodoquin*

(5, 7-Diiodo-8-Hydroxyquinoline)

"meets the requirements of an amebicide free from toxicity and practical for routine use . . ."\*

Diodoquin — an original product of Searle Research—contains 63.9% iodine in a tasteless, oral form which is non-irritating and of negligible toxicity.

Council-Accepted. Available in bottles of 100, 500, 1000 tablets. Item No. 1168600 on the Army Supply Table.

G.D. SEARLE & CO., Chicago 80, Illinois.

\*Silverman, D. N.; Amer. J. Digest. Dis. & Nut., 4:281-282 (July) 1937.



# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

## Reminder to Physicians Under 38 Who Are Essential of Necessity for Filing Proper Selective Service Form

**T**HE Procurement and Assignment Service for Physicians has requested *The Journal* to remind all physicians under 38 years of age, except those holding reserve commissions or who are classified 4-F under Selective Service, of the new Selective Service regulations on the filing of Forms 42, 42-A or 42-A special revised, analyzed on page 349 of the April issue of *The Journal*.

All physicians in this age group, whether in private practice or employed, should file the proper form with Dr. Robert Conard, chairman, Ohio Procurement and Assignment Service for Physicians, 1005 Hartman Theater Building, Columbus 15, Ohio, so this form can be properly endorsed by him, if the physician is essential, and sent to the physician's local Selective Service Board.

It is vital that an essential physician have such form in the files of his local board so it can be considered by the board in event his name is brought up for possible reclassification.

Proper forms may be obtained by a physician either from his local board or from State Selective Service Headquarters, 40 South Third Street, Columbus 15.

### Cincinnati Academy Buys Control of Journal of Medicine

The Cincinnati Academy of Medicine has voted to purchase the controlling stock of the Academy Journal Publishing Company, a private corporation which has published the *Cincinnati Journal of Medicine*. The Journal will become the official organ of the Academy. Dr. Eugene B. Ferris, Jr., assistant professor of medicine, University of Cincinnati College of Medicine, has been appointed editor-in-chief for a three-year period.

At the start, an effort will be made to enlarge the scope of the Journal to include news of Academy actions and of Academy members, College of Medicine current news about faculty, students and alumni, scientific material presented at Academy meetings and at hospital staff meetings, sectional meetings, College of Medicine conferences and clinics, and news of developments in city and county public health fields, and that of the Public Health Federation's various agencies.

### Public Relations by The Editor

Groups recently addressed by Dr. Jonathan Forman, Editor of *The Journal*, included the following: Upper Arlington American Legion Post; Central Ohio agents for the New England Mutual Life Insurance Company; Columbus Nutrition Council; Homemakers Club of the Columbus Y.W.C.A.; women of Morrow County, Mt. Gilead, under the auspices of the Morrow County Branch of the American Association of University Women; annual Rural-Urban meeting of the Chillicothe Rotary Club; Southwest Forum of Allergy, New Orleans; and member, of the Phi Rho Sigma Fraternity, New Orleans.

### Measles Serum Made Available By Red Cross for Civilian Use

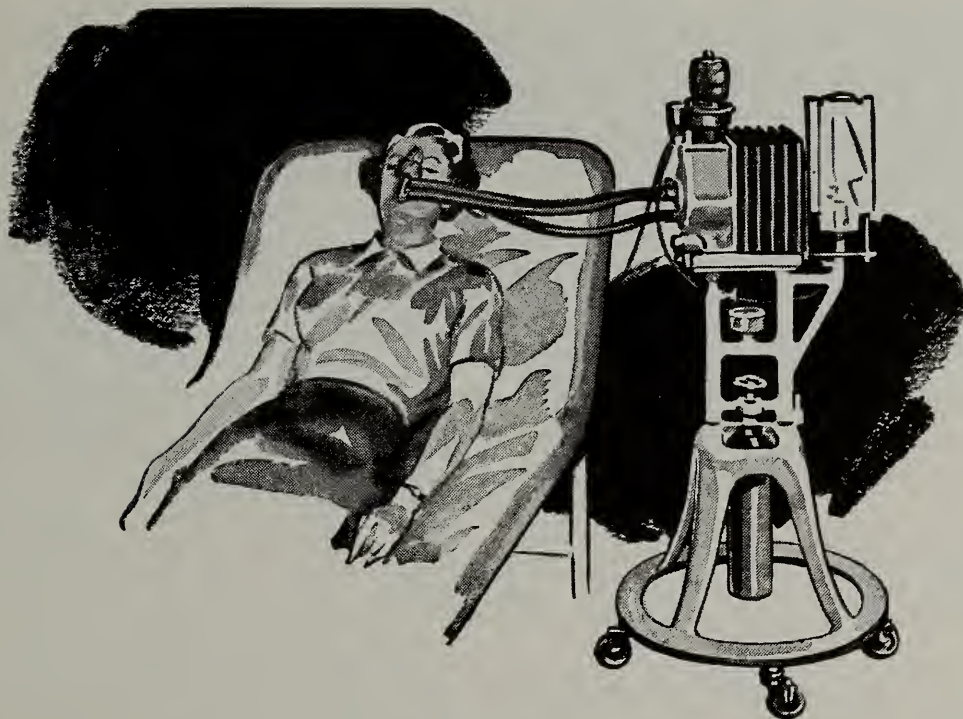
Immune serum globulin (gamma globulin) for the prophylaxis, modification, and treatment of measles is now available for the civilian population through an appropriation by the American Red Cross. This action is in keeping with the policy of the American Red Cross to return to the American people, so far as practicable, any useful blood derivatives accumulated in excess of military needs as a result of its blood donor program.

The serum globulin will be supplied without charge to state and territorial health departments or local health departments where biologics are not supplied by the state, provided that the globulin will be distributed without charge to physicians, hospitals, and clinics, and provided that it will be administered in accordance with established standards and without any charge to the patient for the globulin.

### Medical Care Programs Discussed

"Can Adequate Medical Care for All Be Obtained by Legislation?", was the topic discussed at a Town Meeting held in the Shaker Heights Junior High School, April 10. Governmental medicine was upheld by Marvin C. Harrison, Cleveland attorney, and Miss Margaret Wagner, executive secretary of the Rose Institute. The viewpoint of the medical profession in opposition to the proposal was presented by Dr. Harry V. Paryzek, past-president of the Ohio State Medical Association and the Cleveland Academy of Medicine, and Dr. Charles A. Bowers, until recently a lieutenant colonel in the Medical Corps of the U.S. Army.





## *In Hyperthyreosis, too*

The symptom complex of increased appetite, exaggerated psychomotor tension, hyperhidrosis, and loss of weight, in addition to spelling thyrotoxicosis, also reflects the intense metabolic activity characteristic of this condition. Utilization of nutrients may be 50 per cent above normal.

Whether therapy be conservative or surgical, metabolic deficits must be eradicated and some of the consumed body tissue restored. To this end the intake of virtually all essential nutrients must

be doubled. If surgery is contemplated, nutritional preparation ranks in importance with iodine preparation for a successful outcome.

Ovaltine can be a valuable component of the high-caloric, high-vitamin diet required in hyperthyreosis. This delicious food drink, made with milk, not only increases the caloric intake appreciably, but also significantly augments the intake of complete proteins and of vitamins and minerals, all of which are required in added amounts.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



## *Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,\* provide:

|                        |           |                      |           |
|------------------------|-----------|----------------------|-----------|
| PROTEIN . . . . .      | 31.2 Gm.  | VITAMIN A . . . . .  | 2953 I.U. |
| CARBOHYDRATE . . . . . | 62.43 Gm. | VITAMIN D . . . . .  | 480 I.U.  |
| FAT . . . . .          | 29.34 Gm. | THIAMINE . . . . .   | 1.296 mg. |
| CALCIUM . . . . .      | 1.104 Gm. | RIBOFLAVIN . . . . . | 1.278 mg. |
| PHOSPHORUS . . . . .   | .903 Gm.  | NIACIN . . . . .     | 7.0 mg.   |
| IRON . . . . .         | 11.94 mg. | COPPER . . . . .     | .5 mg.    |

\*Based on average reported values for milk.

# Additional Names Added to Military Roster, Making Total of Ohio Physicians in Services, 3,117

**F**OLLOWING is a list of the names of Ohio physicians added to the Military Roster of the Ohio State Medical Association during the past month, all of whom have been in service for some time but whose names had not been reported to the Columbus office; the names of men receiving promotions and a breakdown by counties, of which 2,593 are in the Army, 451 in the Navy, and 73 in miscellaneous services:

## NAMES ADDED TO MILITARY ROSTER

| Name                 | City            | Rank               |
|----------------------|-----------------|--------------------|
| Brown, John A.       | Morristown..... | 1st Lt., U.S.A.    |
| Friedland, Fritz     | Warren.....     | 1st Lt., U.S.A.    |
| Shelton, James Leroy | Cleveland.....  | 1st Lt., U.S.A.    |
| Wendelken, Harold W. | Kent.....       | Lt. (j.g.), U.S.N. |
| Zlotnick, Sam        | Youngstown..... | 1st Lt., U.S.A.    |

## WIN PROMOTIONS

| Name                | City                | Rank                |
|---------------------|---------------------|---------------------|
| Allison, Robert T.  | Akron.....          | Lt. Col., U.S.A.    |
| Bachman, Henry      | Delaware.....       | Capt., U.S.A.       |
| Baird, Warren A.    | Toledo.....         | Major, U.S.A.       |
| Ballard, R. E.      | Lakewood.....       | Capt., U.S.A.       |
| Bell, Joseph J.     | Cincinnati.....     | Capt., U.S.A.       |
| Berlin, Fred P.     | Wapakoneta.....     | Major, U.S.A.       |
| Dalton, William J.  | Cincinnati.....     | Capt., U.S.A.       |
| Dennis, Gerald H.   | Dayton.....         | Major, U.S.A.       |
| Dinardo, C. J.      | Shaker Heights..... | Lt. Comdr., U.S.N.  |
| Humel, Elbert J.    | Cleveland.....      | Major, U.S.A.       |
| Knapp, Jack D.      | Lore City.....      | Capt., U.S.A.       |
| Kovach, John S.     | Cleveland.....      | Surgeon, U.S.P.H.S. |
| Mallin, Lloyd P.    | Cincinnati.....     | Capt., U.S.A.       |
| McCall, William C.  | Cleveland.....      | Col., U.S.A.        |
| Miller, Ralph       | Cincinnati.....     | Major, U.S.A.       |
| Prugh, Reed C.      | Dayton.....         | Capt., U.S.A.       |
| Pugh, Luther S.     | Perrysburg.....     | Capt., U.S.A.       |
| Rampp, Richard      | Cleveland.....      | Lt., U.S.N.         |
| Smith, Kenneth M.   | Columbus.....       | Lt. Col., U.S.A.    |
| Tichy, V. L.        | Cleveland.....      | Major, U.S.A.       |
| Tuckerman, Jacob B. | Cleveland.....      | Capt., U.S.A.       |
| Updegraff, Ralph K. | Cleveland.....      | Capt., U.S.A.       |
| Weinberg, Norman H. | Cincinnati.....     | Major, U.S.A.       |
| White, Edgar H.     | Cincinnati.....     | Major, U.S.A.       |
| Wolf, Robert E.     | Uhrichsville.....   | Major, U.S.A.       |
| Zeller, Ross M.     | Greenville.....     | Capt., U.S.A.       |

## TABULATION BY COUNTIES

|                  |     |                 |     |                |      |
|------------------|-----|-----------------|-----|----------------|------|
| Adams .....      | 2   | Guernsey ....   | 7   | Muskingum ..   | 9    |
| Allen .....      | 39  | Hamilton ....   | 510 | Noble .....    | 1    |
| Ashland .....    | 12  | Hancock .....   | 12  | Ottawa .....   | 9    |
| Ashtabula .....  | 18  | Hardin .....    | 7   | Paulding ..... | 2    |
| Athens .....     | 11  | Harrison .....  | 4   | Perry .....    | 4    |
| Auglaize .....   | 6   | Henry .....     | 3   | Pickaway ..... | 5    |
| Belmont .....    | 15  | Highland .....  | 7   | Pike .....     | 2    |
| Brown .....      | 1   | Hocking .....   | 4   | Portage .....  | 4    |
| Butler .....     | 34  | Holmes .....    | 2   | Preble .....   | 7    |
| Carroll .....    | 2   | Huron .....     | 17  | Putnam .....   | 6    |
| Champaign .....  | 9   | Jackson .....   | 1   | Richland ..... | 38   |
| Clark .....      | 37  | Jefferson ..... | 28  | Ross .....     | 22   |
| Clermont .....   | 9   | Knox .....      | 10  | Sandusky ..... | 12   |
| Clinton .....    | 8   | Lake .....      | 19  | Scioto .....   | 19   |
| Columbiana ..... | 12  | Lawrence ...    | 7   | Seneca .....   | 11   |
| Coshocton ...    | 4   | Licking .....   | 17  | Shelby .....   | 7    |
| Crawford .....   | 9   | Logan .....     | 8   | Stark .....    | 101  |
| Cuyahoga .....   | 785 | Lorain .....    | 39  | Summit .....   | 161  |
| Darke .....      | 6   | Lucas .....     | 181 | Trumbull ..... | 28   |
| Defiance .....   | 4   | Madison .....   | 6   | Tuscarawas ..  | 20   |
| Delaware .....   | 7   | Mahoning ...    | 141 | Union .....    | 2    |
| Erie .....       | 11  | Marion .....    | 16  | Van Wert ..... | 11   |
| Fairfield .....  | 9   | Medina .....    | 13  | Vinton .....   | 2    |
| Fayette .....    | 2   | Meigs .....     | 3   | Warren .....   | 4    |
| Franklin .....   | 256 | Mercer .....    | 6   | Washington ..  | 8    |
| Fulton .....     | 6   | Miami .....     | 15  | Wayne .....    | 13   |
| Gallia .....     | 5   | Monroe .....    | 0   | Williams ..... | 8    |
| Geauga .....     | 4   | Montgomery..    | 163 | Wood .....     | 19   |
| Greene .....     | 7   | Morgan .....    | 3   | Wyandot ....   | 3    |
| Total .....      |     |                 |     |                | 3117 |

## Ohio Department of Health Is Reorganized; Rheumatic Fever Made Reportable Disease

On the recommendation of Dr. Roger E. Heering, State Director of Health, the Ohio Public Health Council approved a reorganization of the Ohio Department of Health at its quarterly meeting in Columbus, March 25.

Following are the various divisions and chiefs: Administration, James E. Bauman, who is also assistant director of the Department; Child Hygiene, Susan P. Souther, M.D.; Communicable Diseases, Walter J. Smith, M.D.; Sanitary Engineering, F. H. Waring; Dental Hygiene, H. B. Milhoff, D.D.S.; Vital Statistics, Wm. H. Veigel; Nursing, S. Gertrude Bush; Laboratories, James A. Beer, M.D. The following departments are at present headed by acting chiefs on loan from the U. S. Public Health Service: Venereal Diseases, John P. Turner, M.D.; Tuberculosis, Mark W. Garry, M.D.; and Industrial Hygiene, Joseph E. Flanagan.

The Health Council also approved the inclusion of rheumatic fever in the list of reportable diseases. This action is in accordance with a resolution adopted by the House of Delegates of the Ohio State Medical Association at the May, 1944, meeting.

On the suggestion of Dr. Heering, the Council approved modification of the quarantine regulations pertaining to scarlet fever to the extent that they are made somewhat similar to those applicable to septic sore throat. The present health code on septic sore throat requires isolation during the clinical course of the disease.

Final action and the effective date of the proposed new regulations will be determined at the June meeting of the Council.

Members of the Ohio Public Health Council are: L. F. Huffman, M.D., Cleveland, chairman; Ruseel G. Means, M.D., Columbus, vice-chairman; J. Howard Holmes, M.D., Toledo; Samuel F. Ridings, D.D.S., Greenville; Mrs. Lily Cooper, Findlay, and William Helmer, Cincinnati, who is now on active duty in the Navy. A pharmacist will be added to the Council sometime after May 30, 1945, the effective date of H.B. 31, passed at the present session of the Ohio General Assembly.

The Rev. Alphonse M. Schwitalla, S. J., St. Louis, Mo., president of the Catholic Hospital Association of the United States and Canada, and dean of the St. Louis University School of Medicine, has been named moderator of the Federation of Catholic Physicians' Guilds and the editorship of the Federation's journal, *The Linacre Quarterly*.



# Penicillin

## DOSAGE TABLE\*

| INDICATIONS                                                                                                                                                                        | INITIAL DOSE (UNITS)                                                   | CONTINUING DOSAGE (UNITS)                                                                                          | UNITS IN 24 HR.           | REMARKS                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Serious Infections</b> (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus)<br>Adults and children | 15,000 to 20,000                                                       | (a) Intravenous drip: 2000 to 5000 every hr.                                                                       | 40,000 to 120,000 or more | (a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.                                                 |
|                                                                                                                                                                                    |                                                                        | or<br>(b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.                                                       | 40,000 to 120,000 or more | (b) Concentration: 5000 U. per cc. normal saline.                                                                                                         |
|                                                                                                                                                                                    |                                                                        | or<br>(c) Intramuscular drip                                                                                       | 40,000 to 120,000 or more | (c) Total daily dose in 250 cc. normal saline.                                                                                                            |
| Infants                                                                                                                                                                            | 5000 to 10,000                                                         | 3000 to 10,000 intramuscularly every 3 hr.                                                                         | 20,000 to 40,000 or more  | Each dose in 1 or 2 cc. of normal saline.                                                                                                                 |
| <b>Chronically infected</b> compound injuries, osteomyelitis, etc.<br>Adults and children                                                                                          | 5000 to 10,000                                                         | 10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times. | 40,000 to 120,000 or more | Concentration for intramuscular inj.: 5000 U. per cc. normal saline.<br>For intravenous inj.: 1000 to 5000 U. per cc.<br>Supplement with local treatment. |
| <b>Sulfonamide Resistant Gonorrhea</b>                                                                                                                                             | 20,000 every 3 hr. intramuscularly for 5 doses                         |                                                                                                                    | 100,000                   | Results of treatment should be controlled by culture of exudate.                                                                                          |
| <b>Empyema</b><br>Adults and children                                                                                                                                              | 30,000 to 40,000 once or twice daily into empyema cavity               |                                                                                                                    | 30,000 to 80,000          | Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.                                                            |
| <b>Meningitis</b><br>Adults and children                                                                                                                                           | 10,000 once or twice daily into subarachnoid space or intracisternally |                                                                                                                    | 10,000 to 20,000          | Concentration: 1000 U. per cc. normal saline.                                                                                                             |
| <b>Bacterial Endocarditis</b><br>Adults and children                                                                                                                               | 25,000 to 40,000                                                       | 25,000 to 40,000 every 3 hr. intramuscularly                                                                       | 200,000 to 300,000        | Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.                                                     |

\*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### TWO POLICIES OF ARMY AND NAVY NEEDING REVISION

Since the present national emergency arose—before America actually became involved in war—the medical profession has given devoted cooperation and assistance to the War, Navy and Selective Service Departments of the government. The record on this is clear and speaks for itself.

Occasionally, the profession has not been in full agreement with some of the policies which the military has followed. Yet, there has been no criticism, except by a few individual members of the profession, as the profession has felt that complete harmony and cooperation were necessary to win the war.

However, in our opinion, the time has arrived when the medical profession should speak out on a number of policies which appear to be in need of prompt revision. In doing so, we are not in any way casting aside 100 per cent patriotic devotion to the winning of the war but simply calling attention to certain matters which we feel are in need of correction.

First, we disagree with the present policy of the War Department in assigning medical officers, against their will, to Veterans' Administration Facilities. In the legal sense, these institutions are civilian establishments. They should obtain medical personnel in a voluntary manner, as in the past.

Officers who volunteered for service with the Army did so for the purpose of aiding in the winning of the war. They were given to understand that they would be assigned to military service as long as the emergency existed and then be returned to civilian life—sooner if the Army found their services unnecessary for military duties.

The government is doing itself as well as such men an injustice by assigning them to non-military duties. Some of them may desire to become Veterans' Administration physicians. That is a personal matter. If veterans' hospitals are in need of additional medical personnel, such personnel should be obtained in a voluntary manner by making such work more attractive than it is under present conditions.

Unless this policy is changed—and changed quickly—there will be a crack-up of morale in the ranks of the medical corps of the Army, as medical officers see more and more of their colleagues—especially those of older age and many of whom had practices of long standing before entering the service—transferred to institutional

work, important as it is but which has nothing to do with the prosecution of the war.

Second, it is our opinion that the present policies of both the Army and the Navy with respect to rotation of medical officers between foreign and home services have not been successfully administered. There have been too many instances of certain medical officers spending two, two and one-half and even three years in foreign service whereas others are still holding down at-home assignments, even though many of them would welcome overseas service.

We realize that transportation problems must be met. Also, we realize that only competent personnel can be assigned to important posts in battle zones. Nevertheless, as long as officers just as well qualified professionally as those overseas are permitted to hold down assignments in this country and as long as the policy of allowing overseas commanders to have almost the final say as to whether a man shall or shall not be rotated, is followed, inequities can not be minimized.

These criticisms should not be interpreted as an effort to disparage the job which has been done by the Army and Navy. They have performed miracles, against great odds. Nevertheless, they may be a little too close to the scene to fully realize the need for revision of some of their present personnel policies. Criticism, if presented in the right spirit and for the good of the services, can be quite profitable. It may be that perfection can not be achieved under present conditions but improvement can always be effected.

We know that these questions have been discussed with Army and Navy officials and we are hopeful that efforts will be made immediately to make readjustments which will remove at least two sources of serious dissatisfaction.

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### OPEN MARKET SALES MAY BE MENACE TO PUBLIC

In a recent bulletin the National Wholesale Druggists' Association warned that "the release on the open market of surplus war supplies of potent drugs and medicines represents a grave menace to the public health".

Citing "apparently indiscriminate release of enormous quantities" of such drugs by the Procurement Division of the Treasury Department, the bulletin asserts that "the health of the American people may be in serious jeopardy, as was the case following World War I, when dangerous



drugs found their way into unqualified hands".

The association is on record as declaring that "potent drugs and medicines should be distributed only through those who are thoroughly familiar with the medicinal qualities of such products and their possible deterioration".

There is much to be said for the stand taken by the druggists. Sale of such material to the highest bidder, regardless of his qualifications to handle it properly, is indeed a shortsighted policy for the government to pursue. Those supervising the sale of surplus war supplies of drugs and medicines should seek the advice of competent members of the medical and pharmacy professions, both at the national and local levels, as to appropriate means of disposing of such material so as not to endanger the public.

### PHYSICIANS SHOULD BEWARE OF FOOD POINT CHISELERS

According to an announcement by Clyde C. McBee, Columbus District OPA Food Rationing Executive, the number of applications received by the OPA for supplemental food rations from persons claiming poor health has almost doubled since point values on many food items were raised on March 1.

Mr. McBee has expressed concern with this situation because it comes at a time when the supply of meat and other high point foods is low.

Under OPA regulations persons in poor health who may need a special diet may be allowed additional points for supplemental food upon written certification of their physician.

In bona fide cases, the OPA, acting on the advice of medical advisory committees, readily grants points for increased food allotments. Since March 1, however, according to Mr. McBee, the OPA has been receiving what it believes is an unusually large number of such special requests and certifications. Here are a few examples of what the medical advisory committees consider excessive requests:

A man with ulcers of the stomach asked for 80 extra red points and 240 more blue points.

A diabetic wanted 117 points—about 10 pounds of meat.

An applicant said he has a nervous condition which doctors consider unrelated to diet requiring him to eat five extra pounds of meat a week.

A small man weighing over 200 pounds stated he needs to eat five extra pounds of meat a week to reduce.

An 85-year-old lady with bronchial pneumonia wanted 10 pounds more meat a week.

A man who recently had a major abdominal operation wanted 10 more pounds of meat a week.

A woman suffering from nausea during pregnancy wanted eight pounds of meat a week.

Recently a meat clerk reported to a War Price and Rationing Board that he had been berated by an angry woman who held illness rations

and whom he had refused to sell meat after she said she intended to feed it to her dog.

True enough, family physicians are "in the middle" in handling these situations. But, each physician must exercise good judgment and show plenty of courage or the situation will become worse.

In bona fide cases the physician should not hesitate to certify to the need for supplemental food. On the other hand, each time he certifies to an excessive or exaggerated request, filed for the purpose of obtaining more food for members of a family other than the person who is ill, he does an injustice to the deserving ill. If abuses continue, changes will have to be made in the regulations which might place a hardship on those who actually deserve extra rationing points.

Also, the physician who hews to the line will find it easier to live with himself, in our opinion.

Those who misstate their needs under the guise of "illness" certainly do not deserve any consideration by either the OPA or their physician.

There has been a pretty fair relationship between the OPA and the medical profession. Let's keep it that way.

### OHIO NEEDS ANESTHESIA STUDY GROUPS

Great advances have been made in the specialty of anesthesiology during recent years. A great variety of new anesthetic drugs and practices has been introduced. Because of these developments there is a real need for more study of the value of new anesthetic agents and new methods of administration. More accurate studies of deaths and complications resulting from anesthesia will provide a means of evaluating the merits or demerits of the new drugs and procedures.

Anesthetists are approaching this question by establishing anesthesia study commissions. This move deserves the support of the entire medical profession, especially organized medicine.

The work of the Philadelphia County Medical Society, a pioneer in the study commission movement, was described in the March 3, 1945, issue of *The Journal of the A.M.A.*, page 514, by Dr. Henry S. Ruth. It reveals how a study commission may be operated and the benefits which will accrue.

The Ohio Society of Anesthetists formed such a commission in 1941. This group has been doing an excellent piece of work on a limited scale.

The field should be broadened to provide information to more members of the medical profession of Ohio generally. This is where medical organization can help.

It was suggested by the House of Delegates of the American Medical Association in 1944

that anesthesia study commissions should be formed by state and local medical societies.

In all probability it is not feasible for each county medical society in Ohio to form an anesthesia study commission and because of the existence of such a commission by the Ohio Society of Anesthetists, it appears unnecessary for the Ohio State Medical Association to organize such a group.

However, in our opinion, an anesthesia study commission should be formed by each of the larger medical societies of the state, for example those in Cleveland, Cincinnati, Columbus, Toledo, Akron, Canton, Youngstown and Dayton, if these societies do not have such a group at work.

These local groups could coordinate their activities through the Study Commission of the Ohio Society of Anesthetists. Each local group could hold meetings periodically, with physicians from that area of the state as guests, at which findings of the commission after reviewing case reports could be presented and discussed.

As Dr. Ruth pointed out in his paper: "If the inception of study groups of this character was functioning more generally, a more accurate estimate of the mortality rate from anesthetic practices could be obtained. The knowledge of basic improvements in the choice of agent, technic and general management of anesthesia, indicated resuscitative measures, and correct pre-operative and postoperative care could be more widely disseminated. Finally, such group studies would encourage the keeping of more accurate anesthetic records, which to date we have found to be sadly inadequate in general but which are so necessary in determining the role played by anesthesia in the surgical mortality rate."

## CIVILIZATION AND THE CONTEST WITH DISEASE

Recently The Editor had the privilege of reviewing Dr. Henry E. Sigerist's book, "Civilization and Disease", for *The Journal of Higher Education*, published monthly by The Ohio State University.

In the final chapter of his book, Sigerist outlines the steps that our civilization may take in its contest with disease. That chapter called forth the following comments in our review of the book, repeated here because the social and economic changes which affect civilization are certain to affect medicine and medicine's battle against disease:

"The author's lifetime contemplation of medicine as a social science has led him to hope that out of the present conflict ultimately will come a communistic society. We shall move from 'the competitive to the cooperative society democratically ruled on scientific principles'. With

this thinking I cannot agree. I am more inclined to agree with Martin Fischer when he says:

"To avow poverty is no disgrace; true disgrace is in doing nothing to overcome it. The belief of our day is that economics makes men; it is the other way about—man makes economics. The larger man finds the urge to such reaction inside; the dullard only in a press from without, which is disease, hunger and cold. Every handout that is more than the straw to save from drowning should be regarded the unwarranted handicap—be it the filled bowl of the soup kitchen, the free bed of the flophouse, or the 'free scholarship' of the school or university . . . All of which is only another way of saying that communism, state socialism, and the pretty bouquet offered to us as social security cannot do more than cover for a moment the stench of man's death. To give alms is to become the good Christian; to accept them is to be ruined!"

"It is our opinion that American civilization will conduct its fight against disease along the lines of its present successful program."

## Gifts Made to University

Major gifts recently announced by the Board of Directors of the University of Cincinnati include: \$15,000 from the American Dry Milk Institute, Inc.; \$5,000 from the Ralston Purina Co.; \$3,000 from the Ingalls Foundation; and \$1,000 from the William Merrell Co., all for research in nutrition under direction of Dr. Tom D. Spies, associate professor of medicine; \$6,000 from the National Committee for Mental Hygiene, Inc., to psychosomatic research fund in the psychiatry department; \$1,000 from the Universal Oil Products Co. to the Kettering Laboratory building fund; and \$20,000 from the Upjohn Co. for collecting data and preparing manuscript for a monograph covering the work on nutrition at the Spies Clinic, Birmingham, Ala.

## Booklet on Vitamins Available

Entitled "Practical Information on Vitamins", the Ohio Department of Health has published an interesting 56-page booklet for physicians, public health officials, dentists, nurses, nutrition students, teachers, etc. It was prepared by Martha Koehne, Ph.D., senior nutritionist, and edited by Dr. Susan P. Souther, chief of the Division of Child Hygiene. The various vitamins are discussed as to forms available, occurrence in foods, occurrence in body tissues, etc.; absorption and utilization, functions and effects of deficiency, human requirement, interrelation with other factors and properties. Copies of the booklet can be obtained by writing to the Ohio Department of Health at Columbus.

Fostoria—Dr. J. H. Norris, who will be 90 years old on May 13, has practiced medicine for 68 years. He first located in Bowling Green in 1877, moving to Fostoria in 1889, where he has practiced since.



# 29 WORDS

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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### CLINTON

The Clinton County Medical Society held a luncheon-meeting at the General Denver Hotel, Wilmington, April 6. There was a general business session and a discussion of legislative matters.—R. W. DeCrow, M.D., secretary.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during April:

April 3—"Lipoid Nephrosis—A Review of Cases Treated at Children's Hospital", Dr. Katherine Dodd, associate professor of pediatrics, University of Cincinnati College of Medicine.

April 17—"The Effect of Penicillin on the Pathology of Bone in Hematogenous Osteomyelitis", Dr. Edwin P. Lehman, professor of surgery, University of Virginia, Department of Medicine, Charlottesville, Va.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### MIAMI

Dr. Frank E. Stevenson, associate professor of pediatrics, University of Cincinnati College of Medicine, spoke on "Infantile Paralysis", at a meeting of the Miami County Medical Society, April 6, at Stouder Hospital, Troy.—G. A. Woodhouse, M.D., secretary.

### MONTGOMERY

A program on "Non-Tuberculous Diseases of the Chest", was presented by a group of Dayton physicians at a meeting of the Montgomery County Medical Society, April 6, at the Fidelity Building auditorium, Dayton. Speakers included: Dr. L. E. Baker, "Primary Atypical Pneumonia"; Dr. G. Wolverton, "Lung Abscess"; Dr. E. F. Conlogue, "Bronchiectasis"; Dr. A. J. Carlson, "Bronchogenic Carcinoma"; Dr. B. Krug, "Pneumoconiosis".—C. J. Derby, M.D., president.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### MARION

Dr. James H. Warren, Columbus, spoke on "Brucellosis", at a meeting of the Marion County Academy of Medicine, March 6, at the Marion City Hospital.—News clipping.

## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### LUCAS

The Academy of Medicine of Toledo presented the following programs during April:

April 6—General Meeting. "Persistent Problems of Pneumonia", Dr. Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine.

April 13—Section of Pathology, Experimental Medicine and Bacteriology. "X-ray Treatment of Infections", Dr. James F. Kelley, professor of roentgenology, Creighton University School of Medicine, Omaha, Nebr.

April 20—Medical Section. "Combat Neurosis—Military and Civilian Implications", Capt. Sprague H. Gardiner, M.C., chief of neuro-psychiatric section, Billings General Hospital, Indianapolis, Ind.

April 27—Surgical Section. "Field Surgery and Amphibious Operations", Capt. Richard Hotz, M.C.—Bulletin.

### PUTNAM

Dr. Harry A. Neiswander, Pandora, health commissioner of Putnam County, spoke on "Tuberculosis", at a meeting of the Putnam County Medical Society, April 3, at the Court House, Ottawa. He gave a résumé of the activities of the health department in combatting the disease, and outlined a program for the future.—J. R. Echelbarger, M.D., corresponding secretary.

## Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

### CUYAHOGA

The Cleveland Academy of Medicine presented the following programs during April:

April 6—Clinical and Pathological Section. "A Case of Primary Endo-Bronchial Tuberculosis with Pulmonary Manifestations", Dr. Harold G. Curtis; "Two Cases of Interatrial Septum Defect", Dr. Mortimer L. Siegel; "A Case of Cyst of the Thymus", Maj. Paul Gebauer, M.C.; "Hyperthyroidism Treated with Thiourasil", Dr. Edmund E. Beard.

April 13—Combined Meeting, Experimental Medicine Section of the Academy of Medicine and Cleveland Section of the Society for Experimental Biology and Medicine. "Neurosecretion", Dr. Ernest A. Scharrer; "The Chemistry of Isohemagglutinins", L. Pillemer, Ph.D.; "Studies of the Mechanism of Alloxan Diabetes", Dr. Arnold Lazarow.

April 19—Internal Medicine Section. "Clinical Interpretation of Renal Function Tests", Dr. Arthur C. Corcoran.

April 25—Obstetrical and Gynecological Section. "Indications for Therapeutic Abortions", a symposium. "In the Diabetic Patient", Dr. Max Miller; "In the Neuro-Psychiatric Patient", Dr.





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E. M. Zucker; "In the Cardiac Patient", Dr. Harold Feil.

April 27—Regular Academy Meeting. "Fundamental and Clinical Studies of Bile Pigment Metabolism", Dr. Cecil J. Watson, professor of medicine, University of Minnesota Medical School, Minneapolis.—Bulletin.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

Dr. Anton J. Carlson, professor-emeritus of physiology, University of Chicago, spoke on "Vitamins", at a meeting of the Mahoning County Medical Society, March 20, at the Youngstown Club.—Bulletin.

### PORTAGE

"Tumors of the Neck", was the subject discussed by Dr. R. S. Dinsmore, Cleveland, at a meeting of the Portage County Medical Society, April 5, at Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

### COLUMBIANA

Dr. John Henry, Pittsburgh, was guest speaker at a meeting of the Columbiana County Medical Society, April 4, at East Liverpool.—News clipping.

### TRUMBULL

Dr. E. L. MacDougall spoke on "Low Back Pain", at a meeting of the Trumbull County Medical Society, March 22, at the Warren City Hospital.—News clipping.

## Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

### COSHOCTON

Dr. H. B. Davidson, Columbus, was guest speaker, at a meeting of the Coshocton County Medical Society, March 13, at the Riverside Inn, Coshocton.—News clipping.

### TUSCARAWAS

Twenty members were present at a meeting of the Tuscarawas County Medical Society, April 11, at the Hotel Reeves, New Philadelphia. The speakers were: Dr. A. J. Beams and Dr. Harold Feil, associate clinical professors of medicine, Western Reserve University School of Medicine, Cleveland. Dr. Beams spoke on: "Newer Aspects in the Diagnosis and Treatment of Liver Disease", and Dr. Feil's subject was: "Newer Aspects in the Diagnosis and Treatment of Heart Disease". The talks were well presented and merited general discussion.—C. J. Miller, M.D., secretary.

## Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

### MUSKINGUM

Dr. Andre Crotti, Columbus, spoke on: "An Up-to-Date Conception of Cancer", at a meeting of

the Muskingum County Academy of Medicine, April 4, at the University Club, Zanesville. A number of physicians from Perry and Morgan counties were present, including Col. Edgar C. Jones, M.C., ret., McConnelsville, formerly surgeon for the Fifth Service Command, Columbus.—Beatrice T. Hagen, M.D., secretary.

## WASHINGTON

The Washington County Medical Society and members of the dental profession in the county held a joint dinner-meeting, April 11, at the Wakefield Hotel, Marietta. W. L. Sackett, D.D.S., presented a paper entitled: "The Preservation of Deciduous Dentation".—M. S. Muskat, M.D., secretary.

## Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

### FRANKLIN

The Columbus Academy of Medicine presented the following programs during April:

April 2—"Early Rising", Dr. Daniel J. Leithauser, Detroit, Mich. Discussion led by Dr. Verne A. Dodd and Dr. Richard Patton.

April 16—"Management of Meningitis in Infants", Dr. Warren E. Wheeler, associate professor of pediatrics, Ohio State University College of Medicine. Discussion led by Dr. Earl Baxter and Dr. Henry Wilson.—Bulletin.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### LORAIN

"The Differential Diagnosis of Coronary Artery Disease", was the topic discussed by Dr. Roy W. Scott, Cleveland, at a meeting of the Lorain County Medical Society, April 10, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

### RICHLAND

Dr. Harley Williams, associate professor of medicine, Western Reserve University School of Medicine, Cleveland, spoke on "Penicillin", at a meeting of the Richland County Medical Society, Feb. 15, at Mansfield General Hospital. The society also met at the hospital on March 13, when Dr. P. S. Pelouze, Philadelphia, Pa., discussed "Diagnosis and Management of Gonorrhea".—L. B. McCullough, M.D., secretary.

## WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met Monday, March 19, at the Columbus Gallery of Fine Arts, at 1:30 P.M. Dr. Harlan Hatcher gave an interesting review of the book, "Great Son", by Edna Ferber.





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A social hour and tea followed the business meeting, with the local Army wives as honor guests. Mrs. Tom Lewis, hostess chairman, was assisted by Mrs. John Mitchell, Mrs. Huston Fulton, Mrs. J. Q. Brown, Mrs. J. J. Alpers, Mrs. J. B. Gravis, Mrs. J. B. Kistler, Mrs. G. H. Snyder and Mrs. Barret E. Winters.

#### KNOX

The Woman's Auxiliary to the Knox County Medical Society met in April with Mrs. I. S. Rian, hostess, at the Ohio State Sanatorium. A review of the book, "Snow Treasure", by Marie McSwigan, was presented by Mrs. Charles Badger. Mrs. John Drake, President, conducted the business meeting. The members voted to give \$10 to the Society for Crippled Children. Mrs. O. W. Rapp and Mrs. George Imhoff were appointed on the nominating committee. Refreshments were served by Mrs. Rian, assisted by Mrs. O. W. Rapp, co-hostess.

#### MARION

The Woman's Auxiliary to the Marion County Academy of Medicine held a luncheon meeting at Hotel Harding, Saturday, March 17, with Mrs. R. T. Morgan as hostess. Arthur Kellogg was presented in a program of his own piano compositions as the organization's philanthropic program of the year. He was assisted by Mrs. Earl Hale, who sang a group of his songs. Arrangements for a rummage sale were made for April 10. Mrs. J. W. Bull was appointed chairman, assisted by Mrs. Ardeshir, Mrs. Richard Morgan, Mrs. J. G. McNamara, and Mrs. F. T. Merchant.

#### RICHLAND

Mrs. Wilmot W. Peirce was in charge of the program when the Woman's Auxiliary to the Richland County Medical Society met Monday, April 2, at the Woman's Club for a dessert luncheon. Mrs. Peirce conducted a medical study and described health insurance in England. A general discussion followed. Mrs. Leopold Adams, President, presided over the business session. A nominating committee was appointed composed of Mrs. J. L. Stevens, Mrs. C. H. Bell, and Mrs. S. C. Schiller. The surgical dressings committee reported that 5,200 tonsil sponges had been completed in March. Luncheon was served from a buffet table, with Mrs. John Clark presiding. Hostesses were Mrs. L. C. Nigh and Mrs. C. E. Hunter. The final meeting of the club year will take place May 7, at the Woman's Club. Hostesses will be Mrs. W. D. Abrams, Mrs. Charles Shafer, Mrs. H. F. Plaut and Mrs. L. D. Bonar.

#### ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met Thursday evening, April 5. Sixteen members were present. Mrs. Walter Breth, President, presided over a brief

business session, after which a tour was made of the Ross County Historical Museum. Col. David McKell and Mr. Eugene Rigney conducted the group and gave interesting sidelights on various displays.

### Governor Names 17-Man Tuberculosis Advisory Committee

Dr. Roger E. Heering, State Director of Health, is chairman of a 17-member committee appointed by Governor Frank J. Lausche to advise him on tuberculosis activities. The men named had already conducted an extensive survey of conditions in the state and have submitted a report in which the tuberculosis situation in Ohio was described as "serious".

According to the report, Ohio ranks 24th in the nation in the death rate from tuberculosis. In 1942, tuberculosis was responsible for 3.5 per cent of the deaths of white persons and 8.7 of the non-white deaths. Five Ohio cities of more than 100,000 population ranked high in a national poll of deaths from the disease. Youngstown had a death rate of 39.6 per 100,000 population; Canton, 40.6; Cleveland, 42.1; Cincinnati, 42.7; Toledo, 66.1, and Dayton, 67.4. Pickaway County was high in the state with a death rate of 157.8 per 100,000 population and Coshocton County low with a rate of 4.9. The national death rate from tuberculosis was 43.1 in 1942, as compared with 40.9 for Ohio.

Physicians on the committee in addition to Dr. Heering are: Drs. Edgar C. Baker, Youngstown; Lynn E. Baker, Dayton; W. D. Bishop, Greenville, health commissioner of Darke County; H. H. Brueckner, Lima; W. Kenneth Curfman, Cincinnati; Charles A. Doan, Columbus, Dean of the Ohio State University College of Medicine; Wm. D. Hickerson, Cincinnati, Hamilton County Tuberculosis Sanitarium; Clarence L. Hyde, Akron; Myron D. Miller, Columbus, Controller of Tuberculosis for Franklin County; Louis Mark, Columbus; Carl A. Wilzbach, health commissioner of Cincinnati; J. B. Stocklen, Cleveland, Controller of Tuberculosis for Cuyahoga County; and Dr. John P. Hozier, U.S. Public Health Service, Chicago, Ill. Laymen appointed to the committee are: Charon Payne, Columbus, Franklin County Tuberculosis Association; Floyd A. Rowe, Cleveland, Ohio Public Health Association; and Delamer R. Serafy, Canton, Stark County Tuberculosis Association.

Cincinnati—Dr. John P. Romano, head of the Department of Psychiatry, University of Cincinnati College of Medicine, spoke on "The Volunteer's Place in the Hospital", at a meeting of nurse aides at Jewish Hospital. Dr. Romano also addressed the Civic Club recently on "Psychiatry in the Postwar Period."





## Self-Portrait of a Lady

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# In Memoriam

**Homer C. Ballard, M.D.,** Lakewood; Western Reserve University School of Medicine, Cleveland, 1896; aged 77; died March 27. A general practitioner in Cleveland for over 45 years, Dr. Ballard was a member of the staff of Lakewood Hospital, and was formerly on the staffs of St. John's Hospital and Lutheran Hospital. He was an officer of the Medical Corps during World War I. Surviving is an only son, Capt. Robert E. Ballard, M.C., Lakewood, now home on leave from overseas.

**William Lake Beach, M.D.,** Painesville; Ohio State University College of Medicine, Columbus, 1920; aged 55; died March 13. Dr. Beach practiced in Newton Falls for 12 years and then went to Geneva. Ill health forced his retirement there in 1937. He was a member of the Congregational Church. Surviving are his widow, a daughter, seven sisters and three brothers.

**John William Christensen, M.D.,** Dayton; Milwaukee Medical College, 1902; aged 71; died March 18. A resident of Dayton for 14 years, Dr. Christensen was formerly a physician at the National Military Home. He served as Norwegian interpreter at the Versailles peace conference. A veteran of World War I, Dr. Christensen had been a major in the Reserve Corps of the Army. Surviving are his widow, a son, Dr. Aaron Christensen, with the U.S. Public Health Service at Pensacola, Fla.; a daughter, two sisters and a brother.

**Charles Frederick Daniel, M.D.,** Tiffin; Starling Medical College, Columbus, 1907; aged 65; member of the American Medical Association and the Ohio State Medical Association; died March 31. A former president of the Seneca County Medical Society, Dr. Daniel practiced in Tiffin for over 35 years. He was a member of the Holy Name Society, the Poor Souls Society, and the Fourth Degree, Knights of Columbus. Surviving are his widow, four daughters, six sons, including Dr. Walter A. Daniel, a medical officer with the Armed Forces in Germany, and Dr. Arthur Daniel, an intern at St. Vincent's Hospital, Toledo; three sisters and two brothers.

**Alfred Gibson Farmer, M.D.,** Dayton; Kentucky University, Medical Department, Louisville, 1904; aged 68; member of the Ohio State Medical Association; fellow of the American Medical Association, American College of Surgeons, American Academy of Ophthalmology and Oto-Laryngology, and a diplomate of the American Board of Ophthalmology; died April 2. Dr. Farmer had practiced in Dayton since 1919, and

## DIED IN MILITARY SERVICE

**Frank Hugh Maxwell, M.D.,** Mansfield; University of Michigan Medical School, Ann Arbor, 1930; aged 39; member of the Ohio State Medical Association and fellow of the American Medical Association; died March 7, while a captain with the Medical Corps of the U.S. Army on Mindoro Island in the Philippines. Secretary of the Richland County Medical Society in 1936 and president in 1937, Dr. Maxwell was the first Mansfield physician to enlist and the first to go overseas. At press time no particulars were available concerning his death. His last known address indicated that he was in a medical battalion of the 33rd Infantry Division. Surviving are his widow, two daughters, his parents and three brothers, including Dr. Thomas Maxwell, an intern at Cleveland City Hospital, and a sister.

was president of the Montgomery County Medical Society in 1935. From 1904 until 1916, when he became a medical officer in the U.S. Army, Dr. Farmer was in government medical service in Panama. During that time he was on the staff of Gorgas Hospital in Panama, district physician at Gatun and Cristobal and chief of the medical service in Colon Hospital. Dr. Farmer was a major in the Medical Corps for three years during World War I, and had held the rank of lieutenant colonel in the Reserve Corps. Senior staff ophthalmologist at Miami Valley Hospital since 1919, he was chief of staff of that hospital in 1935. He also was a staff member at St. Elizabeth and Good Samaritan hospitals and had been medical examiner for the Civil Aeronautics Authority since 1927. Dr. Farmer was a member of the Masonic Order and Phi Chi fraternity. His widow, a daughter, his mother and a sister survive.

**Thurman Bishop Haas, M.D.,** McArthur; Jefferson Medical College of Philadelphia, 1913; aged 59; died March 15. Dr. Haas practiced in McArthur for nearly 30 years. During World War I he served overseas as a major in the Medical Corps of the U.S. Army. Dr. Haas was a member of the American Legion, the Disabled Veterans and the Masonic Order. His widow, his mother, two daughters, three sons and two sisters survive.

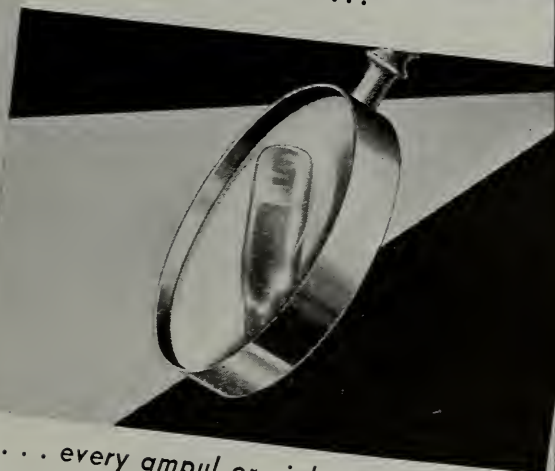
**Frederick Smith Heller, M.D.,** Oak Harbor; University of Michigan Medical School, Ann



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Arbor, 1888; aged 82; member of the Ohio State Medical Association and fellow of the American Medical Association; died Feb. 27. Dr. Heller retired from practice in January, after having been active in civic and professional affairs in Ottawa County for over 50 years. He was a former secretary, vice-president, and treasurer of the Ottawa County Medical Society and in 1926 was the society's delegate to the Ohio State Medical Association. Dr. Heller was a Mason. Surviving are his widow, a son and a brother.

Emanuel Klaus, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1902; aged 70; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Physicians; diplomate of the American Board of Internal Medicine; died March 21. Chief anesthetist at Lutheran Hospital, Cleveland, for 40 years. Dr. Klaus was executive secretary of the International Anesthesia Research Society, which five years ago gave him an award "in appreciation of his devoted service to the world conquest of pain in behalf of suffering humanity". During World War I, he was a captain in the Medical Corps of the U.S. Army. Dr. Klaus was a member of the Masonic Order. His sister and two brothers survive.

Oscar Adair Lashley, M.D., Steubenville; Ohio State University College of Medicine, Columbus, 1924; aged 47; former member of the Ohio State Medical Association and the American Medical Association; died March 20. In failing health for the past two years, Dr. Lashley practiced in Steubenville for 18 years, and was secretary of the Jefferson County Medical Society in 1927-28, and president in 1929. During World War I, he was a member of the Student Army Training Corps. Dr. Lashley was a member of Sigma Pi and Alpha Kappa Kappa, the Episcopal Church, Masonic Order and the Elks Lodge. Surviving are his widow, a daughter and a sister.

William Arthur McConkey, M.D., Canton; University of Wooster, Medical Dept., Cleveland, 1900; aged 74; member of the Ohio State Medical Association and fellow of the American Medical Association; died March 17. President of the Stark County Medical Society in 1927, Dr. McConkey practiced in Canton for 45 years. He had been active in medical organizations, and was a former president of the Sixth District Society. Dr. McConkey was a member of the Canton Medical Library Association, the Presbyterian Church, Masonic Order, and the Alpha Tau Omega fraternity and of the Golden Circle of the fraternity, having been a member for 50 years. He had been a member of the

Canton Board of Health, Canton Clinic and the local Civil Service Commission. Surviving are his widow, two daughters, a son, Capt. Auren W. McConkey, formerly associated with his father and now in the C.B.I. Theater, a sister and a brother.

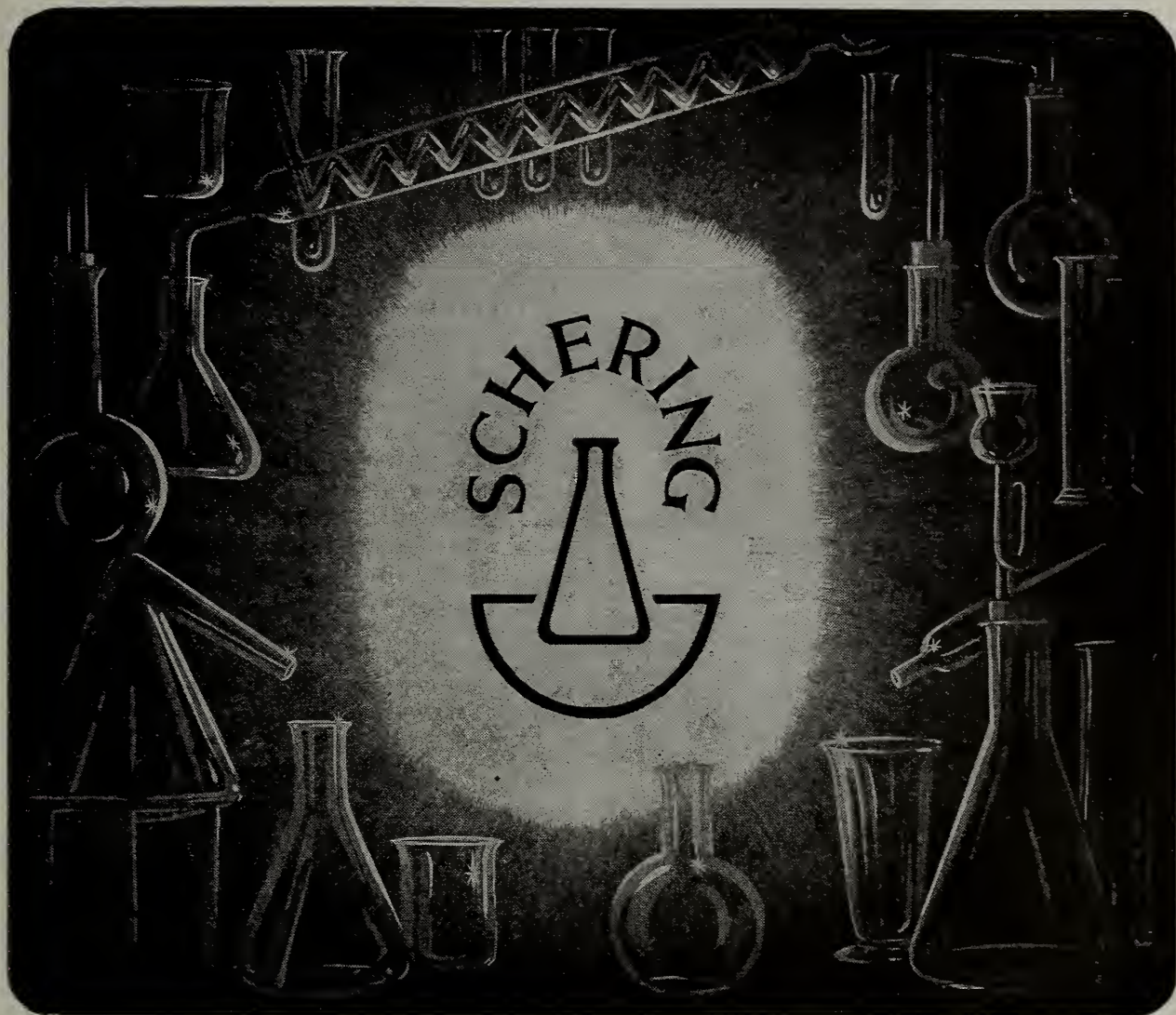
Frank Blair Murphy, M.D., Akron; Medical College of Virginia, Richmond, 1895; aged 77; member of the Ohio State Medical Association and fellow of the American Medical Association; died March 30. Dr. Murphy practiced in Akron for nearly 50 years.

James Ball Naylor, M.D., McConnelsville; Starling Medical College, Columbus, 1886; aged 85; former member of the Ohio State Medical Association and the American Medical Association; died April 1. Nationally known as a poet and author, Dr. Naylor retired from the practice of medicine about 1920, after having practiced in McConnelsville for over 35 years. Early in his career he was an editorial writer for the *Marion Star* and *The Chicago Journal of Commerce*. Dr. Naylor published 17 books of verse and historical novels, the first a book on coins in 1893. Many of his books were concerned with Ohio history, and his last published book was "Vagrant Verse" in 1935, two years after Marietta College conferred on him the Doctor of Literature degree. Prominent in Republican politics, Dr. Naylor was much in demand as a political speaker and also as a lecturer and entertainer. He knew many authors and poets intimately. Surviving are his widow, five daughters and a son.

Roy Whittier Porteus, M.D., Bellefontaine; Rush Medical College, 1906; aged 64; member of the Illinois State Medical Society and Fellow of the American Medical Association; died March 27. Dr. Porteus practiced in Chicago and Rochester, Minn., but had been retired for many years because of ill health. A daughter and two brothers survive.

Arthur L. Pritchard, M.D., Nelsonville; Medical College of Ohio, Cincinnati, 1886; aged 81; member of the Ohio State Medical Association and the American Medical Association; died March 28. An active general practitioner for nearly 60 years, Dr. Pritchard was located in Buchtel for 10 years, moving to Nelsonville in 1896. He recently completed a third term as coroner of Athens County. Dr. Pritchard was a delegate from the Athens County Medical Society to the State Association in 1920. A life-long Democrat, he had been a member of the county executive committee and had served as a member of the local Board of Education. Dr. Pritchard was a member of the Methodist Church, the Masonic Order, Elks Lodge, Order of the Eastern Star, Odd Fellows and





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the Knights of Pythias. His widow, an adopted daughter, three sisters and a brother survive.

**Robert Campbell Tarbell, M.D.,** Columbus; Medical College of Ohio, Cincinnati, 1897; aged 74; died April 15. A psychiatrist, Dr. Tarbell owned the Glen Rest Sanitarium, north of Worthington, and had practiced in Columbus for over 40 years. His widow and a daughter survive.

**Henry Bristol Wideman, M.D.,** Nevada; University of Wooster, Medical Department, Cleveland, 1893; aged 76; died April 5. Dr. Wideman, a former Wyandot County coroner, practiced there for 45 years. He first practiced four years in Fairfield. His widow and a daughter survive.

### National Committee on Artificial Limbs Is Organized

Announcing the organization by the National Academy of Sciences and the National Research Council of a Committee on Prosthetic Devices, *The Journal of the American Medical Association* for April 7 points out that this move brings the promise of new advances and progressive development in the manufacture of artificial limbs. *The Journal* says:

"At the request of the Surgeon General of the Army . . . the National Academy of Sciences and the National Research Council have organized a Committee on Prosthetic Devices. Here for the first time experts in the field of engineering will combine with surgeons and inventors to apply to the manufacture of artificial limbs the knowledge that has been gained in the fundamental sciences.

"The history of prosthetic devices indicates that there has been a failure to apply much of the knowledge that has become available. The tendency has been for manufacturers of devices to hold strictly to models which they have themselves developed and on which they might be able to establish patents. Brace makers and makers of artificial limbs frequently have held as trade secrets some of the improvements which they have developed and would teach them only to their own apprentices. Many new discoveries have been made in alloys of metals which would provide light weight malleability, freedom from rust and other desirable factors. These have, however, been incorporated too infrequently in the making of prosthetic devices.

"The committee will aim to incorporate these new advances into the making of artificial limbs and to bring about as much standardization as possible in parts and mechanisms so as to assure simplification of maintenance and repair. The auspices under which this committee has been established and the inclusion of such names as those of Kettering, Magnuson, McClure and

Wilson mean that progress will be made. The chairman is Dr. Paul E. Klopsteg, professor of applied science at Northwestern University, who gives assurance that the points of view of engineering, production, fitting and servicing, as well as the medical and surgical points of view, will prevail in the work of this committee."

One of the committee members is Dr. Harold Conn, Akron.

### Procedure for Filing Certificates In Illegitimate Births Outlined

There is considerable confusion and misunderstanding among physicians, as well as others, with respect to the proper procedures for the filing of birth certificates covering illegitimate births, births that are presumed to be illegitimate and births that are legitimated by a subsequent marriage of the natural parents, according to W. H. Veigel, chief of the Division of Vital Statistics, Ohio Department of Health.

At the request of *The Journal*, Mr. Veigel prepared the following analysis of this question, including a review of the proper procedures in such cases:

Section 1261-52 of the General Code of Ohio provides for the following in part: "A child born to an unwed mother shall be registered by the surname of the mother." This type of a registration presents no problem to the attending physician when completing a certificate of birth. It is our recommendation that the birth certificate for a child born out of wedlock be completed omitting information relative to the natural father. The child must be given the surname of the mother and the question "Is mother married?" answered with the word "no".

The question of the legitimacy of a child born to a married woman, when it is alleged that her husband is not the natural father, has been a subject of much controversy since the beginning of the war. In dealing with this situation the Division of Vital Statistics has always followed the old Roman law which presumes that all children born in lawful wedlock shall be considered to be legitimate. This is, however, only a presumption of law and can be refuted when it is proved that the husband was overseas for a period of 10 months preceding the birth of a child to his lawful wife.

When a married woman, whose husband has been confined to a penal institution for a number of years, gives birth to a child, the birth of such child is presumed to be legitimate. The lower courts have always sustained this presumption of law on the grounds that the possibility of sexual relations could not be entirely eliminated under these circumstances.

In the bastardy case of Walker, Appellant, v. Clark, Appellee, the State Supreme Court re-



versed the judgment of the Court of Appeals and held that a child conceived during the existence of a lawful marital relation is presumed in law to be legitimate. However, such presumption is not conclusive and may be rebutted by evidence, which must be clear and convincing that there was no sexual relation between the husband and wife during the time such child was conceived. The court recognized the finding and result of a standard and recognized blood grouping test and admitted such evidence. However, such evidence was not conclusive of non-paternity, but was considered for whatever weight the tests may have in proving the fact. In this particular case, the Supreme Court decreed that the husband of Almenda Walker was not the natural father of her child for the reason that the child had a type "A" blood, and the blood of the mother and her husband was found to be type "O".

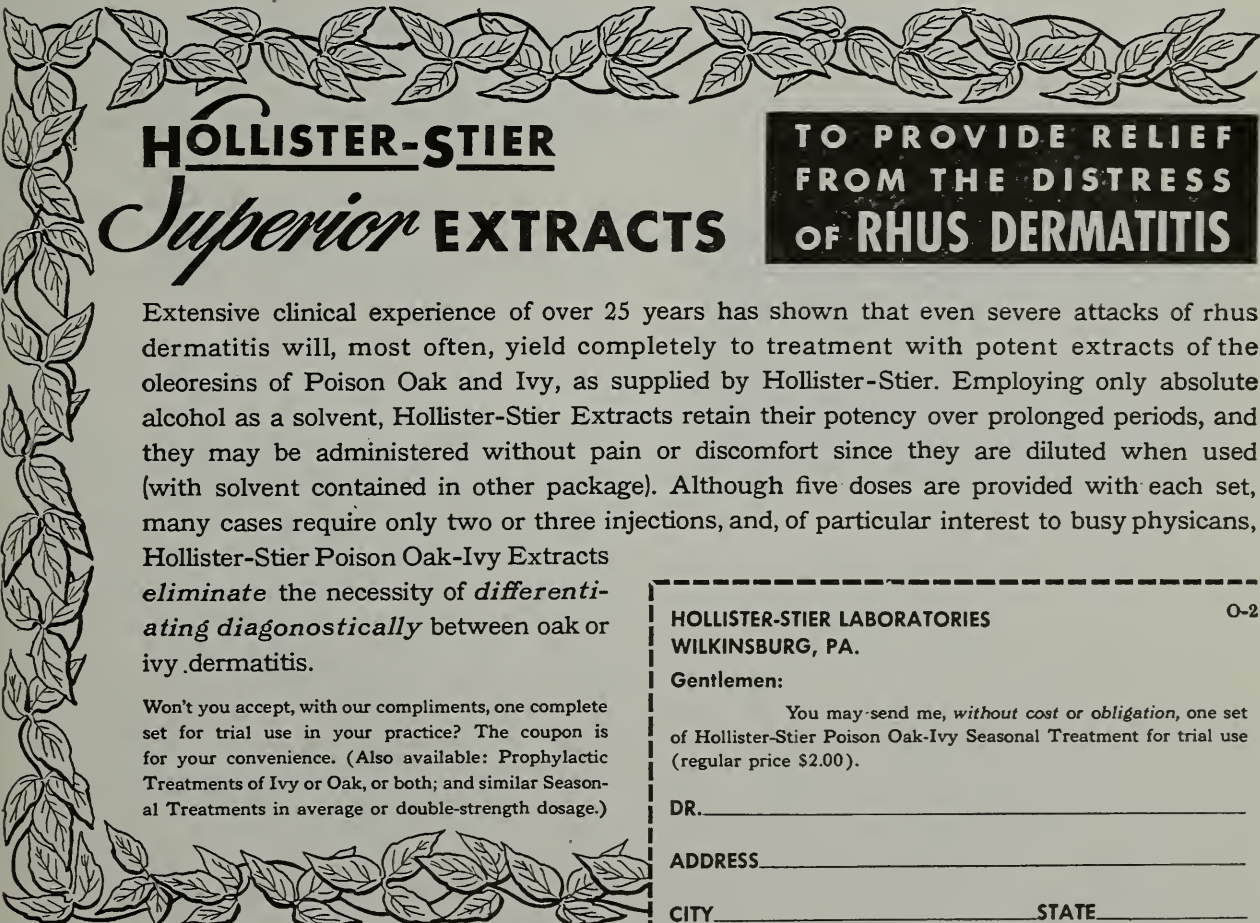
In view of the Supreme Court's decision in the case of Walker v. Clark, the Division must consider a child born or conceived in lawful wedlock to be legitimate. The above court decision does provide, however, that this presumption can be overcome by clear, certain, and conclusive proof. It is, therefore, the Divisions' recommendation that when a woman gives birth to

a child and her husband has been overseas for a period of 10 months or longer, the certificate of birth should be completed in the usual manner. However, information relative to the father of the child should be completely omitted.

When the birth of an illegitimate child has been legitimated by a subsequent marriage of the natural parents, a new birth certificate can be filed with the Division of Vital Statistics, which shall be the same as a certificate of birth would have been filed had the marriage of the parents occurred prior to the birth of the child.

The evidence required by the Division in establishing the new registration of birth is an affidavit "Declaration of Paternity", completed and signed by the father, and a certified copy of his marriage record. When a new certificate of birth is filed in the legitimated name the original certificate of birth then ceases to be a public record, and can only be opened or exposed to inspection upon order of a court of competent jurisdiction.

Columbus—Dr. Frank Tallman, State Commissioner of Mental Diseases, addressed the University Women's Club on the subject: "The Veteran's Road Back".



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# WAR NOTES

From the Philippine Islands: Maj. W. R. Hochwalt, chief of orthopedic service in a general hospital, sees the following Dayton colleagues occasionally: Lt. Col. Roy Arn, Capt. Reed Prugh, Maj. Gerald H. Dennis and Lt. Col. Walter S. Price. . . . Lt. Comdr. Gene Pfanner, also of Dayton, "furnished the best meal on his ship" that Maj. Hochwalt has had for many months. . . . Maj. M. David Burnstine, Columbus, commanding a portable surgical hospital attached to the 5th Air Force. . . . Chief of E.E.N.T. in the same hospital unit as Maj. Hochwalt (the University of Wisconsin unit) is Maj. John S. Goldcamp, Youngstown, with a fellow townsman, Capt. Malcolm Hawk, chief of anesthesia. . . . Has seen Dr. George Bonnell, Columbus, also Dr. A. K. Phillips, Youngstown. . . . Capt. Harry Sisek, Youngstown, reported to be on the island also. . . . "It looks like the Golden Gate in '48", comments Capt. Charles A. Obert, Cleveland, who, like many others, believes that "the rotation policy of getting men back to the States after serving long terms overseas has been functioning very slowly" . . . He's with a medical detachment of an A.A.A. (A.W.) Bn. . . . With the hdqrs. of the 6th Inf. Div., attacking the Yamoshita Line, Maj. R. R. Pliskin, Akron, is on a different type of service than his previous assignment—chief of O.B. and Gyn. at Foster General Hospital, Jackson, Miss. He observes, however, that every Filipino woman seems to be pregnant, "wounded in action".

\* \* \*

From Germany: Capt. Glenn W. Stelzner, Newcomerstown, with a mobile surgical team. . . . Lt. C. R. Crawley, with a medical detachment in an infantry division. . . . With a medical battalion in another infantry division is Capt. Bayard M. Keller, Columbus. . . . When Lt. Col. John R. Woodruff, whose parents reside in Dayton, was transferred from his post as division surgeon of the 9th infantry division to the command of an evacuation hospital, the commanding general presented him with the Legion of Merit for his outstanding work during four and one-half years with the division, reports Maj. Jay P. Roller, Luckey, Wood County, with a medical detachment in the division. Other Ohio medical officers with the 9th, which has been overseas for 30 months and has participated in the fighting in North Africa, Sicily, France, Belgium and Germany, include:

Too many copies of The Journal are being returned to the State Headquarters Office by postal authorities, marked "undeliverable", because of insufficient overseas address. Until recently, the Post Office, through its directory service, would supply missing information, such as the unit or organizational designation of an addressee who had furnished only an A.P.O. number. A new regulation requires that copies of future issues of a publication mailed to such an addressee will not be accepted and dispatched overseas unless a complete military address, including unit designation and A.P.O. number appears. So, if you run across an Ohio colleague who says he is not receiving The Ohio State Medical Journal, just suggest to him that he send us his correct, complete address. We'll do the rest. Then when your address is changed, notify us promptly. This little bit of cooperation will save The Journal office and the postal employees a lot of unnecessary work in forwarding and re-forwarding Journals—and will assure you of getting The Journal regularly.

Maj. Wm. M. Jennings, Sylvania; Maj. Norman H. Weinberg, Cincinnati, and Maj. Henry P. Limbacher, Cleveland. . . . All were present at the ceremony when Col. Woodruff received the award.

\* \* \*

From La Belle France: Maj. G. A. Palmer, Akron, C.O. of a hospital train, based in Paris, lives on the train, and isn't interested in taking up railroading after the war. . . . Occasionally sees Maj. Harold J. Gordon, formerly of Akron, later with the Ohio Department of Health, Columbus. . . . Capt. Howard Farmer, Fletcher, Miami County, with an infantry medical detachment, like many folks, is "unable to justify the war or any war from the point of human sacrifice". . . . Assigned to a general hospital, but on detached service with the same hospital train as Maj. Palmer, is Capt. Max Sternlieb, Wadsworth. . . . Capt. Howard Lauer is with the Hdqrs. Det. of a Reinf. Bn. . . . Capt. G. A. Pirard, acting chief of radiology in a general hospital, with a fine setup in a former French



city hospital. His "piece de resistance" is a German X-ray machine, which in the course of a hasty retreat by the enemy, was left intact and in good working condition. . . . Chief of anesthesia, supervisor of the operating room and in charge of central supply, is the assignment of Capt. R. C. Miller, Dayton, with a general hospital in Paris. . . . Six operating teams did 58 surgical cases in four hours. Quite a feat! . . . Maj. Cyrus R. Wood, Port Clinton, chief of the medical service in a general hospital, with two other Ohio docs in the group: Major Harold Waltz, Sandusky, chief of E.N.T., and Lieut. Irving Berger, Cleveland, chief of neuropsychiatry. . . . Capt. Luther W. High, Millersburg, with a medical clearing company, reports Lieut. Mason Jones, Chillicothe, in the immediate vicinity, with a medical collecting company. . . . Lt. Col. Myron A. Weitz, Cleveland, after 20 months in Africa, now with a station hospital, located in a beautiful section of France in buildings "which would make it a show-place anywhere in the States" . . . Lt. Col. Herman E. Wilkinson, Van Wert, is C.O. of the 11th Field Hospital, which has earned five battle stars in 22 months overseas, having pioneered in forward surgical service in Sicily, Italy and France. . . . As reported in the April issue of *The Ohio State Medical Journal*, the unit re-

cently received the Meritorious Service Unit Plaque. Col. Wilkinson mentions a few Ohio medical officers he has run across overseas: Lt. Col. Maurice Kane, Greenville; Maj. Kenneth Lowry, Troy; Maj. Forrest Lowry, Urbana; Capt. Milton Levine, New Boston; also the following O.S.U. medical graduates: Col. Wendell A. Weller, commanding a 750-bed evacuation hospital; Col. Clement St. John, with an Army Surgeon's Office, and Col. Byron Steger. A classmate of Col. Wilkinson in O.S.U., '31, Col. Francis Kintz, is also overseas. Capt. John H. Blackburn, Kalida, is another Ohioan riding a hospital train. . . . He saw Maj. Gilman D. Kirk and Maj. Robert C. Kirk, Columbus, in England, and Maj. Thomas Curran, Columbus, on the Continent.

\* \* \*

Our first letter from Sweden: Maj. Floyd A. Potter, Toledo, in the office of the Military Air Attache, Legation of the United States of America, Stockholm, acknowledges receipt of his 1944 membership card, mailed to him on Aug. 29, 1944, and received March 7, 1945, via Langley Field, Va.; Orlando, Fla.; Alamogordo, N. M.; England, the continent, back to Washington, D.C., thence to Sweden. Maj. Potter has met some Swedish physicians who are friends of Ohio physicians, and he writes: "If any men at home would

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like to contact some of their Swedish friends, I would offer my services as personal emissary". He would also be glad to get information for anyone interested in recent advances in medicine made by the Swedes. His address is: Maj. Floyd A. Potter, O-400929, Mail Room 1C774, Military Intelligence Service, Pentagon Building, Washington 25, D.C.

\* \* \*

**Reported missing in action Dec. 21, 1944,** Maj. G. Deshler Fridline, Ashland, is a prisoner of war in Germany. On Feb. 20 he wrote Mrs. Fridline that he was in Stamm Lager 4-F, H-57, where he was working in the P.O.W. hospital.

\* \* \*

**In and around Belgium:** Capt. Abe A. Lichtblau, Canton, with a medical battalion, was at St. Vith and Vielsolm during the Runstedt breakthrough last December. His outfit was able to do its share in stopping the rush of the Nazi horde. . . . Maj. E. H. White, with a general hospital unit composed mostly of Cincinnati colleagues, located in March "at the edge of a small town in Eastern Belgium, in new beautiful brick buildings built in 1939 for Belgian troops but occupied until last September by the Germans. Quite a show place". . . . Wondering whether they'll be in the Army of Occupation or sent to the Far East. . . . "Cincinnati would look good to most of us about now", he says. . . . No other Ohio doctors with Maj. Walter J. Tims, Youngstown, also anxious to get home. . . . Maj. H. M. Amstutz, Lancaster, with an evacuation hospital for 2½ years, landed in Normandy D plus 11, and took an active part in that campaign as well as the succeeding battles of Northern France and Germany. After a month in Germany, got mixed up in the Battle of the Bulge before being moved back into Belgium. Since the first of the year, he has visited with Lt. Col. Claude S. Perry, Columbus; Col. Paul S. Fancher, formerly of Delaware; Maj. Wm. Jennings, Sylvania, and Maj. Delbert Minder, Columbus. Capt. Vernon Noble, native of St. Marys, is with the same hospital unit.

\* \* \*

**From the United Kingdom:** Maj. Chas. L. Shafer, Mansfield, with a general hospital unit since Feb., 1944, after a year and a half with the Air Corps "in the great southwest", attached to the West Coast Training Command. . . . Other Ohioans in the unit are Capt. Robert Schoene, Columbus, and Capt. E. D. Schwartz, Cleveland, the latter having been attached to the hospital overseas, after previously serving a trick in the Aleutians. . . . Capt. O. E. Cress, Van Wert, with the Hdqrs., Eastern District, United Kingdom Base, doing consultation in

traumatic and general surgery. . . . Maj. William F. Hunting, Cincinnati, executive officer and chief of the Contagious Disease Section of a general hospital.

\* \* \*

**Out there in the C.B.I. Theater:** Capt. A. W. McConkey, Canton, with a portable surgical hospital, serving two "crack" Chinese divisions in the Salween campaign, was at the Burma border to greet the first jeeps from India marking the opening of the Burma Road on Jan. 27. Capt. McConkey gets his *Journal* irregularly but eventually, as he changes living quarters once every one to three weeks, and the "postman has to have intuition" to find him. While pack-train hikes across the rugged terrain is tiring somewhat, he recommends a seven to ten-day truck ride out the Burma Road for a real rigorous life. The road goes up and down and round and round and if it isn't dusty, it's muddy, and a smooth surface is a rare finding, says Capt. McConkey. . . . Also with a portable surgical hospital, for 2½ years, the last year of that period in with Chinese troops, is Capt. George B. Haydon, Cincinnati. . . .

Now in India, after some time in Burma, Capt. Ray Martz, Hamilton, is with an airdrome squadron in a combat cargo group. . . . Medical liaison officer with a Chinese Division, Capt. Franklin D. Rodabaugh, Toledo, has enjoyed working with Maj. Ben Houghton, Columbus, who grew up in China. . . . Capt. Rodabaugh has found himself with a civilian practice in addition to his Army duties. He says: "The complaints are quite varied as are the 'fees' collected. They bring gifts of eggs, chickens, bananas, potatoes, etc., which contribute to the mess fund" . . . Capt. Julius W. Pastor, Cleveland, is assisting in the establishment of a field hospital for the care of Chinese soldiers at a field headquarters of the Chinese Combat Command in South-Central China. He went to India in Dec., 1943, after spending seven years in North Africa and undergoing a bombing while in the Mediterranean. Assigned to the Y-Force, the American Military Mission which trained, equipped, supplied and advised the Chinese Expeditionary Force for the Salween Campaign to reopen the Burma Road, Capt. Pastor went to China in March, 1944.

\* \* \*

Maj. A. R. Callander, Delaware, is in an Army hospital in Hawaii convalescing after an appendectomy. He had been on his second tour of duty in the South Pacific.

\* \* \*

Pfc. Howard A. Elliott, 20, son of Dr. and Mrs. Floyd M. Elliott, Ada, was killed in action March 9. He was an infantryman with the Third Army, and had completed a year's study as a



pre-medical student at Ohio State University before entering the service. Dr. Elliott formerly represented Hardin County in the State Legislature. He was a captain in the infantry during World War I. Howard is survived by three brothers and his parents.

\* \* \*

Maj. M. L. Matteo, Cleveland, with an infantry division, reports that he was married on Oct. 7, 1944, to Mrs. Hilda May Pugh, Yeoucl, Somerset, England.

\* \* \*

Lt. Comdr. J. L. Fisher, Youngstown, has Lt. (j.g.) L. H. Thomasson, Wellington, as a shipmate out in the Pacific.

\* \* \*

Recently returned from an overseas station, Capt. Stephen Donath, Toledo, is a patient at Fletcher General Hospital, Cambridge.

\* \* \*

Now in his fifth year of active duty, Col. Royal G. Grossman, Cleveland, is post surgeon at Camp Atterbury, Ind.

\* \* \*

Capt. William J. Neal, Archbold, overseas since March, 1943, is squadron flight surgeon for a P-47 Thunderbolt squadron busily engaged in keeping the Germans in the Po Valley, Italy, miserable.

Out in the Mariannas, Lt. Arthur H. Spreen, Cincinnati, is now one of six physicians on the staff of a small 100-bed Naval hospital. Another naval medical officer out there, Lt. R. T. Warburton, North Canton, suggests a reunion of the Ohio docs on duty in the Mariannas.

\* \* \*

Maj. B. M. Brandmiller, Youngstown, doesn't disclose his location, but he has been there 16 months, "with nothing but jungles and natives and absolutely no other sign of civilization".

\* \* \*

Formerly on the staff of a station hospital on Bougainville, Maj. Philip B. Giber, Girard, is now on duty at a dispensary, Ft. Knox, Ky.

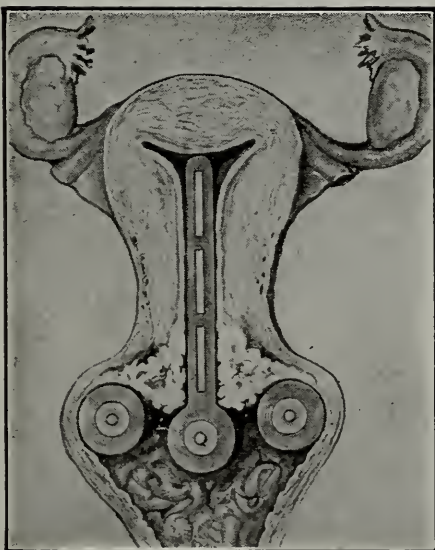
\* \* \*

The station hospital at Camp McQuaide, Calif., is the present location of Capt. James F. Whitacre, Toledo, recently returned from overseas. He is chief of the out-patient clinic.

\* \* \*

Maj. Harry G. Brown, Cincinnati, reports that he "is very fortunate in being the post surgeon and C.O. of the station dispensary on a lovely post with beautiful offices and quarters" in Panama. He further says: "I am not a drinking man, but if you are, I'll break your heart by telling you that Old Granddad, Old Forrester,

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\* \* \*

The Bronze Star Medal has been awarded Capt. Ralph J. Kessler, Cincinnati, his citation reading as follows:

"For meritorious service in combat from 2 March, 1944, to 10 January, 1945, in Italy. Capt. Kessler, as Station Platoon Commander, established the collecting station in well forward positions. This frequently placed his station under enemy artillery fire, as was the case in the vicinity of Belvedere, Italy, from 17 October, 1944, to 18 October, 1944, and again near San Clemente, Italy, from 18 October, 1944, to 9 November, 1944, where incoming shells scored many hits on his station, and resulted in numerous casualties in the troops of nearby areas. Despite long hours of duty under these trying circumstances, Capt. Kessler calmly and expertly treated the sick and wounded without asking for respite, and refusing relief. His conscientious application of expert medical knowledge did much to relieve the human suffering of war, and aided in saving the lives of many of our wounded soldiers."

\* \* \*

Formerly assistant to the Air Surgeon, Washington, D.C., Lt. Col. Richard L. Meiling, Columbus, has gone overseas with the U.S. Strategic Bombing Survey.

\* \* \*

After 30 months in England, Maj. Fred P. Berlin, Wapakoneta, is a patient at Percy Jones Gen. and Conv. Hospital, Battle Creek, Mich.

\* \* \*

Lt. Col. Louis E. Lieder, Cleveland, is on the medical service at Walter Reed General Hospital, Washington, D.C. The first nine months of his four years of active duty were spent at the Station Hospital, Fort Jackson, S.C. Since then he has been at his present post.

\* \* \*

Assigned to the Ferrying Division of the Air Transport Command when he entered the service in August, 1942, Capt. James J. Pagano, Canton, accompanied flight convoys through Central and South America during the first two months of his Army career. He then became chief of surgery of the Third Ferrying Group at Romulus, Mich., and in June, 1944, was transferred to the Brownsville Air Base, Texas, as post surgeon. Capt. Pagano has been chief of

surgery at the Station Hospital, for the Fifth Ferrying Group, Love Field, Dallas, Texas, since January of this year.

\* \* \*

Lieut. J. L. Bilton, Cleveland, is now on the surgical staff at the Naval Hospital, Great Lakes, Ill., after 21 months overseas with the Third Marine Division.

\* \* \*

Bits of news about Columbus medical officers from *The Bulletin of the Columbus Academy of Medicine*: Capt. Chas. V. Edwards, assisted in the re-conquest of the Philippines, as did Maj. George H. Bonnell, Jr. . . Lt. Comdr. Harve M. Clodfelter, on sea duty in the Pacific. . . Maj. Frank E. Hamilton, now chief of the general surgery section and assistant chief of the surgical service in a general hospital, to which he was recently transferred from the First Auxiliary Surgical Group. . . "After we broke out of Normandy, we followed the Army on the rat race across France, ending up in front of Metz. There we received front casualties from the time we first held the city until we were pushed out and later slowly made our way forward again. With the opening of the Dutch corridor, my surgical team was sent up to Holland by air and for a time when the Corridor was narrow, it was hot enough to suit anyone's fancy. Following that, we were sent to Aachen, Germany, where we worked until recently", writes Maj. Hamilton. . . Capt. N. O. Rothermich, recently made Chief of the Medical Service in a general hospital in Sydney, Australia, recently surprised by a visit from Maj. Harrison Evans.

\* \* \*

The official report of British casualties in the fighting forces in the war from Sept. 3, 1939 to Nov. 30, 1944 has been issued. The total for the whole British Empire is 1,043,554. This consists of 282,162 killed, 80,580 missing, 386,374 wounded and 294,438 prisoners of war. Of the casualties 635,107 come from Britain, 78,985 from Canada, 84,861 from Australia, 34,115 from New Zealand, 28,943 from South Africa, 152,597 from India and 28,946 from the colonies. These figures are not the total casualties, for they exclude civilian casualties due to enemy action and casualties of merchant seamen.

\* \* \*

Capt. Charles W. McGavran, Columbus, who has been on detached service at the Mayo Foundation, Rochester, Minn., for three months training in roentgenology, has reported back to the Long Beach Army Air Field, Long Beach, Calif., where he is chief of roentgenology and assistant in medicine.

\* \* \*

A special badge has been authorized for Medical Department personnel who daily share with the infantry the hazards and hardships of combat. Made of silver, the Medical Badge is ellip-



tical in shape with the caduceus and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. It is to be worn on the left breast above decorations and service ribbons.

The badge was established in recognition of "the important role being performed by medical personnel on duty with infantry units, especially infantry battalions." Enlisted and officer personnel below field grade (major) and regimental surgeons regardless of rank are eligible for the badge if they have seen combat service with the infantry since December 7, 1941.

\* \* \*

Maj. Dorrence S. James, Delaware, with an evacuation hospital in either Holland or Belgium—we're not sure which, reports an Ohio round-up recently when Lt. Col. Claude S. Perry, Columbus, came up from Liege for a visit. Lt. Col. George King, Alliance, and Capt. Ed. Ditch, Caldwell, are other Ohio members of the evacuation hospital staff.

\* \* \*

Stationed on the same ship for 18½ months, Lieut. Frank R. Moore, Cincinnati, is hoping for a change of duty soon.

\* \* \*

Maj. J. Stewart Hagen, Jr., Cincinnati is home on leave after 27 months in North Africa and the Mediterranean Theater. He expects to report back at his base in Foggia, Italy's largest airport.

\* \* \*

"Expecting orders to the Pacific but still fighting the Battle of the Carolinas", is the situation of Lt. Comdr. G. A. Rowland, Cleveland, a flight surgeon attached to the Marine Air Wing and chief medical officer at Congaree Air Base, Columbia, S. C., an auxiliary base of Cherry Point.

\* \* \*

Relatives of Capt. George W. Campbell, Columbus, captured in the Philippines after the fall of Bataan, have received word that he is safe and well at Osaka prison camp, Japan. This is the first message from him in 18 months. A graduate of Western Reserve University School of Medicine in 1938, Dr. Campbell was chief resident at Memorial Hospital, Elyria, before entering the service in 1940.

\* \* \*

Some new locations within the United States: Maj. Arthur Dobkin, Akron, M.D.R.P., Lawson Gen. Hosp., Atlanta, Ga.; Comdr. Harry Sage, Columbus, N.A.P.D., San Bruno, Calif.; Capt. M. C. Beyer, Akron, Billings Gen. Hosp., Ft. Benj. Harrison, Ind.; Maj. Lewis K. Reed, Youngstown, Crile Gen. Hosp., Cleveland; Capt. Bernard S. Malasky, Cleveland Heights, 369th Fighter Gp., 400 Fighter Squadron, S.A.A.F., Stuttgart, Ark.; Lt. A. J. Huesman, Cincinnati, 15th Naval Bn., Camp Park, Calif.; Maj. Clark Pritchett, Columbus, Conv. Center, Bowman Field, Louisville, Ky.; Maj. Archie Fine, Cin-

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### Highlights for June

- ★ **THE EFFECTS OF SULFONAMIDES ON THE BLOOD**—from American Journal of Clinical Pathology ★
- ★ **NUTRITIONAL IMPROVEMENT OF CHILD MENTALITY**—from American Journal of the Medical Sciences ★
- ★ **MANAGEMENT OF HYPERTENSION**—from Journal of Missouri Medical Assn. ★
- ★ **AMINOPHYLLIN IN VIRUS PNEUMONIA**—from Stamford Medical Bulletin ★

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Capt. J. G. Rosenbaum, Brecksville, A.A.F., Waycross, Ga.; Capt. Horace S. Mabee, Cleveland, Vet. Adm. Fac., Waco, Texas; Capt. Russell N. Brown, Centerville, Ft. George Wright, C-H, Spokane, Wash.; Maj. Sidney E. Wolpaw, Cleveland Heights, Bruns Gen. Hosp., Santa Fe, New Mex.; Capt. A. B. Yasinow, Cleveland Heights, A.G. and S.F., Redist. Sta., Hot Springs, Ark.; Capt. John A. Reibel, Ashland, Dispensary, Columbus A.S.F. Depot, Columbus; Lieut. Franklin C. Schlueter, Cincinnati, Reg. Sta. Hosp., Patterson Field, Fairfield; Lt. Comdr. Joyce I. Hartman, Cleveland, N.A.P.D., San Bruno, Calif.; Capt. E. N. Sachs, Dayton, Chief of E.N.T., Base Hosp., Morrison Field, West Palm Beach, Fla.; Capt. O. J. Nicholson, Norwalk, Harmon Gen. Hosp., Longview, Texas; Lt. Comdr. W. C. Clark, Dayton, U.S. Naval Hosp., Charleston, S. C.; Capt. Patrick J. Fusco, Warren, 113th Evac. Hosp., Camp Gordon, Ga.; Maj. David P. Ward, Pemberville, A.S.F.T.C., Ft. Lewis, Wash.; Lieut. William T. Preston, Toledo, Sta. Hosp., A.A.B., Honestead, Fla.; Lieut. Robert L. Piercy, Youngstown, Madigan Gen. Hosp., S.C.U., 1915, Tacoma, Wash.; Lieut. Harry Sigel, Cincinnati, 318th Gen. Hosp., Fort Ord, Calif.; Capt. Herbert F. Kessinger, McArthur, A.A.F. Redist. Station No. 1, Atlantic City, N.J.; Maj. Asher Randall, Youngstown, 314th Gen. Hosp., Camp Roberts, Calif.; Capt. Wayne C. Smith, Van Wert, School of Aviation Medicine, Randolph Field, Texas; Maj. James M. Harsha, Washington C. H., C.O., 378th Sta. Hosp., Camp Gruber, Okla.; Maj. Clyde M. Dummer, Cincinnati, F.A.T.S.C., Reg. Hosp., Patterson Field, Fairfield; Lt. Col. Chas. J. Prochaska, South Euclid, Sta. Hosp., A.A.F., Harlingen, Texas.

\* \* \*

Lt. Comdr. R. G. Witwer, Cleveland, is one of the survivors of the bombing of a carrier off Iwo Jima last February. Over 300 of his shipmates were lost, including nine of his 18 pharmacist mates. Dr. Witwer floated in the chill waters of the Pacific for two hours before being picked up by a destroyer escort.

\* \* \*

Dr. Lester W. Sontag, director of the Fels Research Institute, Yellow Springs, is a member of a medical mission expected to leave for Italy in April. Sponsored by the Unitarian Service Committee and the Congregational Christian Service Committee, the group is under the direction of Dr. Elmer L. Sevringhaus, of

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the University of Wisconsin, and is going to Italy under the auspices of the United Nations Relief and Rehabilitation Administration. The mission plans to establish scientific standards for all large-scale feeding programs by U.N.R.R.A. in newly-liberated and destitute areas and to bring direct benefits to many thousands of individuals in Italy suffering from prolonged malnutrition.

\* \* \*

The Bronze Star Medal has been awarded to Capt. Harry H. Robinson, Cleveland, for meritorious services at Kwajalein and Eniwetok, Feb. 1 to July 4, 1944. Here's the citation:

Assigned to the shore party of a battalion combat team, Capt. Robinson landed on the Kwajalein beach in the seventh wave before the arrival of any medical units. He gave medical attention and care to all beach casualties for eight hours, during which time he was constantly under enemy fire. For four days thereafter, Capt. Robinson, with assistants, attended all casualties that passed through this beach area and was responsible for saving many lives. Between February 22 and July 4, 1944, in addition to his regular duties, Capt. Robinson was responsible for the medical care of 115 Marshallese natives on Eniwetok Atoll. His constant and intelligent care of these natives was responsible for their good health and contentment and materially aided the military effort.

\* \* \*

"At many of the general hospitals", said Brigadier General Raymond W. Bliss, U.S.A., Assistant Surgeon General, "there are well-constructed barracks, built with an eye to the future, which were used to house overseas hospital units during their training period. Those barracks are now being turned into wards for patients. Permanent barracks, built to house the hospital staff, are also being converted into wards and are being replaced with temporary barracks which can be quickly constructed."

Over 50,000 more patients are being cared for in the Army's general hospitals than was the case three months ago. During the past month about 1,200 casualties arrived from overseas daily.

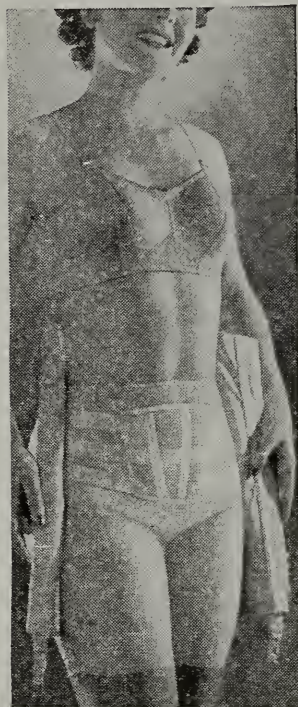
\* \* \*

After 33 months in England with active combat groups, first with the Royal Canadian Air Force and later with the American Air Force, Maj. Ivor McCampbell, Akron, has been assigned to the 31st Air Depot Group.

\* \* \*

A number of Dayton and Miami Valley physicians are on the staff of a station hospital commanded by the commanding general of the Oise Supply section in France for evacuating patients when the hospital was threatened with destruction by blasts from a bombed ammunition depot. They are Maj. Walter A. Reiling, Capt. C. E. Clark,

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Capt. A. V. Black and Capt. Paul Petraglia, Dayton; Capt. John F. Torrence, Germantown, and Capt. Harold D. Bockoven, Verona.

\* \* \*

Since the invasion of France, Maj. F. A. McCammon, Van Wert, has been doing administrative work in an air disarmament group. Maj. McCammon was on the Normandy coast at "H" hour on "D" day. After convalescing from an injury for six weeks, he was in Ireland until three months ago, when he returned to France. Like many other medical officers who have been overseas for two years or more, Maj. McCammon would like to know "why the U. S. is 'off limits' to us as far as rotation and leaves are concerned". That, Major, is a \$64 dollar question, which we wish we could answer.

\* \* \*

Capt. H. M. Duckwall, Dayton, nine months in the E.T.O. with a medical aviation group, reports that Capt. John P. Urban, Columbus, is with the same outfit.

\* \* \*

After 31 months in service, a year of which he spent in England, Maj. C. J. Czarnecki, Toledo, reverted to inactive duty and civilian practice on March 14. He has reopened his offices in Toledo, for the practice of Internal Medicine and Endocrinology. Just before returning to the United States, Major Czarnecki was commanding officer of a Port Hospital.

\* \* \*

Dr. Gilbert I. Cullen, aged 75, former Cincinnati physician, was among internees released from Santo Tomas in Manila. A graduate of Cincinnati College of Medicine and Surgery in 1890, Dr. Cullen practiced in Cincinnati until he went to the Philippines in 1898 on a Government hospital ship. Later he was a quarantine officer on an island there. He was married in the Islands and never returned to the United States.

\* \* \*

Assistant for three years to Dr. Chas. D. Heisel, Cincinnati surgeon, before entering the service, Capt. W. R. Chambers is head of the general surgical section of a general hospital in France.

\* \* \*

In the Mediterranean Theater of Operations for 27 months, Capt. Bertrum Firestone, Youngstown, is on the staff of a general dispensary at Marseille, France. Maj. James Ockington, Cleveland, is the acting C. O. Capt. Firestone's 19 months in North Africa were interspersed with missions to Corsica, Sardinia, Sicily and Italy. He landed in France shortly after the invasion.

\* \* \*

Maj. Thomas A. Weaver, Jr., Cincinnati, is following the Seventh Army with a 750-bed hos-

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pital, which has had as many as 1500 patients at one time. The neurosurgery section, of which he is chief, has been kept busy most of the time, the evacuation hospital being the place where all of the primary neurosurgery is done on the Seventh Army front. The unit was organized at the University of Illinois and is composed largely of men from Chicago and vicinity. After a brief sojourn in Africa, it has functioned in Italy and now in France.

\* \* \*

Lt. Col. Donald M. Glover, Cleveland, is the new commanding officer of the Fourth General Hospital, the "Lakeside Unit", in New Guinea. Previously chief of surgery, he succeeds Col. Wm. C. McCally, Cleveland, home for reassignment after three years in the Southwest Pacific.

\* \* \*

"Matters progress more satisfactorily now, after many discouragements, so I guess we can bear it", is the comment of Col. Paul G. Hansen, Warrensville, who has been in China for 19 months.

\* \* \*

Lieut. Sam Tetelman, Cleveland Heights, is back in Vancouver Barracks, Washington, after a trip to New Guinea via the Hawaiian Islands, as a transport surgeon on a small vessel.

\* \* \*

Dr. H. Worley Kendell, Surgeon (R), U.S.P.H.S., Dayton, has been transferred from the Chicago Intensive Treatment Center, where he was medical director, to the State Board of Health, Jackson, Mississippi, to serve as the medical director in organizing a unit for the treatment of neurosyphilis. It is planned to employ fever therapy as the treatment of choice, with which Dr. Kendell was associated at the Miami Valley Hospital in Dayton, under the direction of the Kettering Institute for Medical Research. Mississippi is inaugurating a statewide program to treat the large group of patients with neurosyphilis as a prevention program to keep them out of the State Hospital in later years. Dr. Kendell reports that the state has an excellent and broad V.D. program with three rapid treatment centers, now admitting over 1,500 patients each month.

\* \* \*

Lt. Col. Edward E. Woldman, Cleveland, was recently transferred from a station hospital to a general hospital in England. He is chief of the medical service.

\* \* \*

Lt. Col. Charles Berns, Cleveland, chief of surgery of an evacuation hospital in France, has the following Ohioans associated with him on the surgical staff: Maj. Harold M. Crumley, Chillicothe; Capt. Walter A. Hoyt, Jr., Akron;

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\*Welch, Henry, and Hunter, Albert C., Method for Determining the Effect of Chemical Antisepsis on Phagocytosis, Am. Jnl. of Public Health, Vol. 30, No. 2, Feb. 1940.

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★

★

Capt. Gordon T. Wagner, Cleveland. They were recently visited by Maj. Y. A. Venar, who has been transferred to a numbered general hospital. Col. Berns's unit landed in France shortly after the invasion. For the past three months they have been about 12 miles from the German border, in the vicinity of December counter-attack, but did not have to move.

\* \* \*

Infirmiry surgeon at an air depot in India, Capt. Ben Widzer, Cleveland, says that his copy of The Ohio State Medical Journal is avidly read by native Indian physicians, and appreciated too—because it is their only source of current medical literature. British medical journals are not available in India at present. Capt. Emery Braun, Columbus, heads the dispensary at the depot. "Things are humming here and we hope to be back with you soon!" comments Capt. Widzer, optimistically.

\* \* \*

Lt. Col. Maurice Kane, Greenville, with the headquarters of an infantry division, has discovered that an Ohio State '33 classmate, Capt. Kent Latham, Pittsburgh, also is in Italy, with an evacuation hospital.

\* \* \*

Chief of the surgical service in a general hospital which is taking care of battle casualties in France within a day of wounding, despite the fact that the engineers are still working on the buildings, was the situation confronting Maj. Paul E. Adolph, Bellevue, early in February. The operating room was set up in three different places in three weeks to escape the invasions of the engineers. Maj. Adolph expected to move into the permanent operating room in a few weeks.

\* \* \*

Maj. E. F. Damstra, Dayton, doing the orthopedic work in a general hospital in a forward area in France, modestly says: "As for my own work, I can't say much except that I'm just another Army Doc doing my duty as laid down by Army regulations". Capt. John Osmond, Cleveland, X-ray man in the unit was recently transferred to head the radiology service in another hospital.

\* \* \*

Capt. Chester R. Lulenski, Cleveland, is in the 307th Airborne Medical Company which received the following Presidential Citation:

"The 307th Airborne Medical Company, 82nd Airborne Division is cited for extraordinary heroism and outstanding performance of duty in the initial assault on the Northern coast of Normandy, France, on 6th June, 1944. It landed by glider on D-Day, June 6, 1944, on the Cotentin Peninsula in the area surrounding .....

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France. Landings were made in the face of artillery, machine gun, and anti-aircraft fire from organized enemy positions, and movement from the landing fields were effected through small arms and artillery fire from mobile anti-airborne landing groups of German forces in the area. Although the gliders and personnel were widely scattered on landing, the superb discipline of this Company enabled it to assemble and organize their personnel, ambulance jeeps, and medical supplies. They established a clearing station as soon as they reached friendly lines and evacuated more than 500 casualties from regimental aid stations during the next 24 hours. Almost without rest or pause for 48 hours, officers and enlisted men of the company gave the utmost of skill and will to accomplish their work of mercy in caring for the wounded. At times they were under direct attack by artillery and small arms fire, were always immediately ad-

jacent to active fighting, and even subjected to bombing directed against nearby artillery batteries. Duties were performed unhesitatingly with superior efficiency and tireless devotion to duty. The courage and perseverance shown by members of the 307th Airborne Medical Company are worthy of emulation and reflect the highest traditions of the Army of the United States."

\* \* \*

Reported to be en route home from his post in Greece, Lt. Col. William E. Brown, Cincinnati, is chief medical officer of the Balkan Mission for the U.N.R.R.A. In recognition of his service to Greece, Col. Brown was made a Commander of the Order of the Phoenix by the Greek Government.

\* \* \*

Here and there with Columbusites: Writing from a sandbagged foxhole out in the Pacific area, Capt. J. M. Foley hadn't had his clothes off for a week. He's with a field hospital . . . Comdr. Judson Wilson, assigned to a recently-commissioned hospital ship on the West coast, expects to be in the Pacific area by Summer.

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**VACANCY:** Office of the late D. C. Barber, M.D., Grafton, Ohio, is vacant and the large practice that was his is without services of a resident doctor. Need is great and opportunities unlimited. Any doctor interested in this location can secure information by inquiring of Wayne C. Black, attorney, 700 Elyria Savings & Trust Bldg., Elyria, Ohio, or Mrs. D. C. Barber, Main St., Grafton, Ohio.

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. . . Twenty-seven months overseas, Lt. Col. Kenneth M. Smith is chief of medical service in a hospital in England. . . . In a field hospital "on the 50-yard line", Major D. M. Minder, was at Bastogne. . . . Maj. Frank Hamilton, chief of the general surgery section and assistant chief of the surgical service with a general hospital, had a narrow escape from death during the shelling of Aachen. . . . Capt. Geo. B. Watson, still in India with a general hospital, but hoping to go to China.

\* \* \*

Capt. Jack Widrich, Cadiz, was on Corregidor when General MacArthur returned and the Stars and Stripes were raised there for the first time in three years. He "had some swell Filipino meals in Balanga, Bataan, at the home of a doctor who graduated from Ohio State".

\* \* \*

Capt. George P. Fitzgerald, Jr., Springfield, with an infantry division in the Third Army, delivered the six-pound baby girl of a German woman in a bomb shelter by the illumination of a flashlight. A German woman, who spoke English, acted as interpreter in the case. According to a news story, Dr. Fitzgerald received "four apples, eight eggs and a couple of drinks" for his services.

\* \* \*

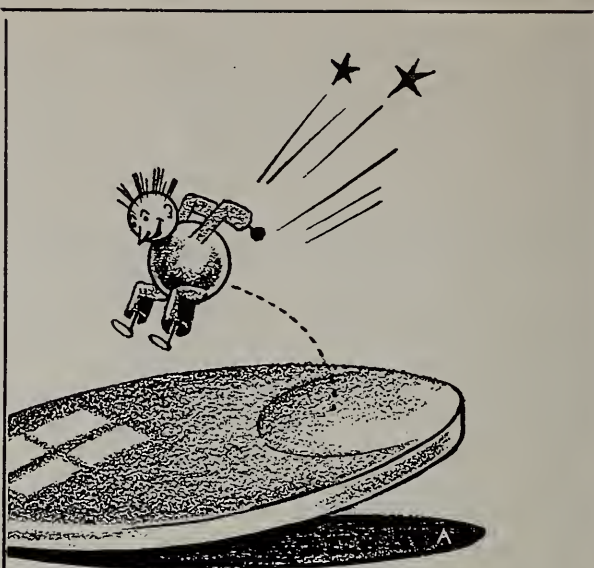
Dr. James A. Doull, professor of hygiene and public health, Western Reserve University School of Medicine, recently went to England for two weeks on a special mission for the Department of State. In 1943 Dr. Doull was sent to the Southwest Pacific to handle distribution of hospital supplies, drugs, etc., and last year was in London as a medical consultant for the U.N.R.R.A.

\* \* \*

Col. Herbert B. Wright, Cleveland, chief of professional services for the U.S. Strategic Air Forces in Europe, has been elected to membership in the Academy of Surgery of France, an honor accorded few surgeons who are not French-born.

\* \* \*

News about Clevelanders on many fronts from the *Bulletin of the Cleveland Academy of Medicine*: After service on a carrier, a cruiser, and at a base hospital, Lt. George T. Day just left a destroyer on which he saw some action and now is taking it easy as S.M.O. of a stevedore Bn., with the Seabees in the Marianas. . . . Lt. Richard Rampp, on a destroyer. . . . Ward officer and cardiologist in a large hospital in Paris, Capt. J. B. Tuckerman had a nice visit before D-day with Lt. Col. Carl Francis in England. Met Maj. Robert G. Bartunek in Belgium and Maj. Wm. F. Boukalik, with a traveling



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surgical team. . . . Maj. M. C. Archer, back from foreign service. . . . At Ft. Sheridan awaiting reassignment, Capt. R. E. Ballard landed on D-Day, fought through St. Lo and was also in the breakout at Aachen. . . . Capt. G. G. Bassett in Belgium. . . . Lt. Col. Spencer Braden, chief of neuro-surgery, Nichols General Hospital, Louisville, Ky., with 700 cases on service. . . . Maj. A. S. Broglio, doing medicine in a fairly large hospital in Western England. . . . Lt. H. E. Christman, with the Navy at Congaree Field, Columbia, S.C. . . . Capt. Myron Crawford, somewhere on the Continent. . . . Lt. D. J. Dugan, at Walter Reed Hospital. . . . Comdr. J. Stanley Gardner, enjoying Hawaii. . . . Lt. Comdr. A. M. Glomb at the "Country Club of the Pacific. . . . Capt. Robert Gnehus, in China. . . . Lt. Comdr. James Gray, with the U.S. Naval Hospital, Parris Island, S.C. . . . Capt. Carl Hahn, moved from Belgium to Germany in February. . . .

Capt. J. V. Heiman, on medicine in a hospital in France. . . . Lt. Col. R. S. Jauch, second in command of a hospital in France. . . . Chief of surgical service at an air field for training aerial gunners, is Maj. J. B. Kelker. His address: Station Hospital, Buckingham Army Air Field, Ft. Myers, Fla. . . . Maj. J. H. Lazzari, chief of surgery in a 2,000-bed hospital, comments: "Have enjoyed my tour of the S.W.P.—there is a certain beauty to New Guinea that one meets after two years of it, but she is like a pretty woman, that when you come too close to her, you see the pimples". . . . Capt. Lawrence Lazarus, at the Station Hospital, Camp Hood, Texas, which is "losing more doctors and gaining more patients daily". . . . Maj. H. P. Limbacher, with fighting troops in Germany. . . . Lt. Comdr. S. C. Lind, doing surgery at U.S. Naval Hospital, Santa Margarita Ranch, Ocean-side, Calif. . . . In fine accommodations at the Ritz-Carlton Hotel while at the A.A.F. Redistribution Center, Atlantic City, is Lt. S. J. Matt, but expecting reassignment soon. . . .

Maj. J. W. Ockington, in France, went to the Riviera Bowl football game on New Year's Day. . . . Lt. Col. Louis Pillersdorf, Battey General Hospital, Rome, Ga., has a new son. . . . Executive officer of a general hospital in New Guinea which received a presidential citation for its work in the Buna campaign, is Maj. A. A. Pimsner. Formerly chief of the surgical service, he has been with the outfit on tropical service two years. Only ten of the original 47 officers in the unit are left, the others having been lost by sickness, transfer or rotation. . . . Capt. H. H. Roenigk, stationed in India, but travels back and forth over the hump to China frequently, and has been along on raids over Japan. . . . After three Winters in the Aleutians, Lt. Col. Edward Sherrer was sent to Miami

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**OBSTETRICS**—Two Weeks Intensive Course June 4.

**ANESTHESIA**—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

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for reassignment. . . . Maj. V. L. Tichy, at the A.S.F. Regional Hospital, Fort Francis E. Warren, Cheyenne, Wyo., since his return from New Guinea last May. . . . Surgeon of the Mediterranean Base Section and C.O. of a hospital in North Africa, Lt. Col. G. A. Tischler recently played golf on the private course of a Pascha. . . . Capt. R. L. Updegraff, Jr., at Fort Sam Houston, Tex. . . .

Lt. Comdr. Charles Ward, at Purdue Naval Training School, Lafayette, Indiana, a year, after two years in the Pacific. . . . Maj. L. B. Wylie, in Paris. . . . Capt. Joseph D. Vandeveld, in Japanese prison camp in the Philippines. Family received card from him two weeks after Christmas indicating that he was in excellent health. . . . Lt. Col. Howard P. Taylor, as chief of surgery in a hospital outfit, operated in a cathedral in Leyte. Witnessed General MacArthur's famous "I Have Returned" speech.

### Joins Nestle's Milk Products, Inc.

Announcement has been made by Nestle's Milk Products, Inc., the Dr. James T. Lowe has been appointed Director of Nutritional Research for the company. Dr. Lowe has been with the Wisconsin Alumni Research Foundation for the past ten years in the capacity of technical counsel and special field representative.

Akron—Dr. V. C. Malloy has been appointed chairman of the personal and public health development on the Western District health and safety committee of the Boy Scouts of America.

Mansfield—Dr. J. L. Stevens recently began his 51st year in the practice of medicine here.

Middletown—"Woman and Her Health", was the subject of an address made by Dr. Mabel E. Gardner at a meeting of the Cincinnati Business and Professional Women's Club.

New Lexington—Back in his office after a short illness, Dr. J. G. McDougal will begin his 64th year of medical practice here on May 1.

Columbus—Dr. George T. Harding has been named a trustee of the Franklin County Tuberculosis Hospital.

Cleveland—Members of the Industrial Nurses Section, District No. 4, were guests of Jack & Heintz Co., at the Hotel Carter, Cleveland, on the occasion of the 50th anniversary of the entrance of the first registered nurse into industrial nursing. Speakers were: Dr. Louis J. Karnosh, "Psychiatry Applied to Industry"; Dr. Roy Scott, "Coronary Disease Common to Industry"; Dr. James Driver, "Industrial Dermatitis", and Dr. John R. Toomey, "The Threat of Polio to Industry".

Fremont—Dr. C. I. Kuntz has been appointed city health commissioner, succeeding the late Dr. C. L. Smith.

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## Bureau of Industrial Hygiene Formed By Cleveland Health Department

Western Reserve University has made available the research and educational facilities of its School of Medicine to the Cleveland Bureau of Industrial Hygiene which has been set up by the Cleveland Division of Health to help reduce health hazards in industry.

The bureau, which has established quarters in Room 207 at the School of Medicine Building on the Western Reserve campus, was established on an order of the Cleveland Welfare Director as a cooperative venture of labor, industry, the medical profession and the public. Herbert G. Dyktor, former chief engineer of the Michigan Department of Health, has been appointed director.

As a basis for the operation of the bureau the Division of Health is making a survey of 160,000 individuals in Cleveland manufacturing plants to determine their health status and the state of their working environment.

According to Cleveland Health Commissioner H. J. Knapp, much of the bureau's work will be educational and advisory. It will try to help plants in obtaining the services of physicians and nurses and in installing proper safeguards. When necessary it will use the police powers of the division of health to enforce proper standards, but will place a great amount of emphasis on lectures, movies, pamphlets and other educational work.

Discussing the bureau's relationship with the School of Medicine, Dr. James A. Doull, professor of hygiene and public health, said the medical students will profit by its being situated there.

"It is necessary for the medical students to learn the safety and hygiene measures which must be taken in the construction, equipment and operation of factories in order to prevent accidents and occupational disease", he commented. "It is hoped that the director of the bureau and members of the staff of the city division of health staff will contribute to instruction of students. In the future and at present the application of medical science is being broadened in the selection of the right man for the right job in industry, both from the psychological as well as from the physical standpoint. It is hoped that the whole School of Medicine will take a greater interest in problems of the industrial worker, such as the nature and cause of fatigue and similar problems."

Youngstown—Dr. Joseph B. Stocklen, Cleveland, controller of tuberculosis for Cuyahoga County, was guest speaker at the annual Spring meeting of the Mahoning County Tuberculosis and Health Association.

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# Do You Know - - -

The next examinations to be given by the State Medical Board are scheduled for June 18, 19, 20 and 21 at Columbus.

\* \* \*

Business as usual was the program of the day for Dr. A. Rhu, dean of the Marion County medical profession, who celebrated his 96th birthday on April 5. Dr. Rhu is believed to be the oldest practicing physician in the state.

\* \* \*

After reviewing the wartime boom in birth rates, the U.S. Bureau of the Census estimates that the 1945 population will be 139,126,000, the highest estimated figure in the country's history. The population in the census-taking year of 1940 was 131,600,000.

\* \* \*

The Jackie Krumholtz Foundation has been organized in Cincinnati to combat leukemia and other rare blood diseases. Incorporators are: Arthur Krumholtz, Springfield; Msgr. Cletus A. Miller, dean of the Institutum Divi Thomae, and Benjamin S. Schwartz, Cincinnati attorney. The foundation is named for the four-year-old son of Mr. Krumholtz who died of leukemia last August 16.

\* \* \*

The Association to Control Epilepsy, 22 East 67th St., New York 21 and the American Epilepsy League, 50 State St., Boston, are jointly sponsoring an educational campaign to disseminate knowledge in this field. One of the first ventures was the distribution of a pamphlet: "Epilepsy—The Ghost Is Out of the Closet".

\* \* \*

The American College of Chest Physicians has cancelled its annual meeting scheduled to be held in Philadelphia in June. The executive council of the College voted to hold a business meeting of the Board of Regents at Chicago, June 17.

\* \* \*

Psychiatrists will be included in a physicians' committee to study mental states which induce many cancer sufferers to postpone visiting a physician until it is too late, the Cancer Control Council of the Cincinnati Public Health Federation has announced.

\* \* \*

The Board of Directors of the Metropolitan Life Insurance Company has made the following appointments: Dr. Albert O. Jimenis, Dr. Haynes H. Fellows and Dr. Anthony J. Lanza, formerly assistant medical directors to be associate medical directors; Dr. George M. Wheatley, formerly assistant medical director to be assistant vice-president, welfare.

The American Psychiatric Association, which claims to be the oldest medical society in America, has cancelled its 101st Annual Meeting which was to have been held in Chicago in May. The Association was founded in 1844, the first meeting being held at the Jones Hotel, Philadelphia, Oct. 16, 1844. Meetings have been held annually with the exception of 1861 during the outbreak of the Civil War.

\* \* \*

For the first time in the history of the state, a widespread tuberculosis control program has been inaugurated by the State Department of Health involving patients and employees in all state welfare department institutions. Nearly 40,000 patients and employees will soon undergo chest X-rays as part of the control program. A mobile unit, including a physician and a technician, will be loaned by the U. S. Public Health Service for the survey.

\* \* \*

The dental and medical faculties of Columbia University have been merged by action of the Board of Trustees. The dentistry staff will have "departmental autonomy" and some members will have seats on the faculty of medicine, but the curriculum will be in charge of a "committee on dental education", a majority of whose members will be chosen by the dental staff.

\* \* \*

Dr. Christopher Leggo, a surgeon in the U. S. Public Health Service, and formerly chief of the Division of Industrial Hygiene, State Department of Health, resigned recently to join the medical staff of the Clinton Engine Co., Knoxville, Tenn.

\* \* \*

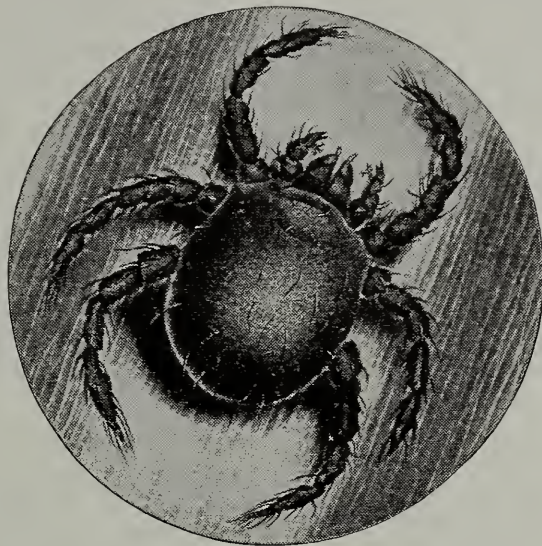
Wyeth, Inc., has given Western Reserve University \$12,600 to conduct studies of toxins and anti-toxins. The Research will attempt to determine more closely the active principles of toxins and anti-toxins. The work will be carried on by Louis Pillemer, Ph.D., research immunologist of the University's Institute of Pathology, under the director of E. E. Ecker, Ph.D., professor of immunology.

\* \* \*

Patients in 11 Ohio state mental hospitals soon will begin making camouflage nets for the Army, according to an announcement of Welfare Director Frazier Reams. Work on 400 of the nets will begin as soon as materials are received from the Army. Hospital participating include: the Columbus State Hospital, Columbus Feeble-Minded Institution, and the state hospitals at Athens, Cleveland, Dayton, Lima, Longview, Massillon, Toledo, Gallipolis and Apple Creek.



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\*Romeo, Z. J.: Sulfur and Soap as Effective Prophylaxis Against "Chiggers" (Red Bugs) in the Army, Mil. Surgeon, 90:437-439 (April) 1942.



# The Physician's Bookshelf

**Who's Important in Medicine.** (*Institute for Research in Biography, Inc., 320 Broadway, New York 7, N.Y.*) It is customary for the organs of organized medicine to complain about "Who's Who In Medicine Directory" and to promote the directories of the A.M.A., the Specialties Boards, the American College of Surgeons, and the American College of Physicians. All of these are good but here is a reference work that is more useful to those who have need of biographies than any except perhaps the regular directory of the A.M.A., which is indispensable. This contains complete biographies of 300 to 1,000 words for over 10,000 important physicians. So it will no doubt find a nice reception in all reference libraries of biography.

**Dietotherapy.** *Clinical Application of Modern Nutrition*, edited by Michael G. Wohl, M.D., (\$10.00. *W. B. Saunders Co., Philadelphia*) attempts to provide the practicing physician and the student of medicine with a sound knowledge of both current advances in and practical application of the rapidly expanding science of nutrition. The job is well done by 58 well known and recognized contributors.

**Hay Fever Plants.** *Their Appearance, Distribution, Time of Flowering, and Their Role in Hay Fever with Special Reference to North America*, by Roger P. Woodhouse, Ph.D., (\$4.75. *The Chromica Botanica Co., Waltham, Mass.*) is a text of extreme value to all who are interested in the subject. It is a beautiful volume which interprets the botanical facts of hay fever in terms of their clinical significance.

**Constitution and Disease Applied Constitutional Pathology**, by Julius Bauer, M.D., (\$4.00. 2nd Ed. Revised. *Grune & Stratton, Inc., New York City*) continues to have a valid function: That is, to make us all give a little more attention to the constitutional or genetic standpoint in our practices. "In clinical medicine the laboratory is a good servant but a bad master." Its cordial reception is another indication that the American physician is coming to realize that medicine is more than applied exact science. It requires an integrative comprehension of the patient's personality.

**Manual of Tropical Medicine**, by T. T. Mackie, M.D., George W. Hunter, M.D., and C. Brooke Worth, M.D., with collaboration of six other well known authorities, (\$6.00. *W. B. Saunders Co., Philadelphia*) provides a concise statement of the recent available and authentic information concerning the more important tropical diseases. It does just that. Our own Ed Cushing and Hardy Kemp had a hand in its making.

**What Doth It Profit a Man?**, by Vincent S. Stevens, (\$2.00. *Dorrance & Co., Philadelphia*) depicts the vicissitudes of the Chamber of Commerce Secretary. It is the story of a civic fight against tuberculosis. The author should know what he writes about. He worked for the Detroit Board of Commerce and served as secretary for the Akron Chamber of Commerce.

**The Psychology of Diet and Nutrition**, by Lowell S. Selling, M.D., and Mary Anne S. Ferraro, M.S., (\$2.75. *W. W. Norton & Co., New York City*) presents one of the most pressing of current problems. There is still a vast army of people who are improperly nourished because of fixed ideas and prejudices about food. Here we have an informative discussion—the result of a collaboration between a psychiatrist and a dietitian.

**The March of Medicine.** The New York Academy of Medicine Lectures to the Laity, 1944, (\$1.75. *Columbia University Press, New York City*) is the ninth annual series of these lectures. This volume reflects the impact of the war as we read: "Morale and Propaganda" by Edward A. Strecker, M.D.; "Food and Civilization" by Charles Glen King; "The Past, Present, and Future of Chemotherapy" by Colin M. MacLeod; "Medicine in a Changing World" by Reginald Fitz; "The Effects of Science Upon Human Beings" by Sir Gerald Campbell; "War and Epidemics", Thomas T. Mackie. Indeed a stimulating volume worthy of a place with its predecessors.

**A Textbook of Pathology of Labor, Puerperium, and the Newborn**, by Charles O. McCormick, M.D., (\$7.50. 191 Illustrations. *The C. V. Mosby Co., St. Louis*) represents the contents of the author's lectures before the senior students at the School of Medicine, Indiana University. A selection of the essentials by a competent teacher, carefully and adequately illustrated.

**The 1944 Year Book of Industrial and Orthopedic Surgery**, edited by Charles F. Painter, M.D., (\$3.00. *The Year Book Publishers, Chicago*) presents much that has to do with reconstruction problems and the experiences of surgeons in the military service. In spite of the war, the book has maintained the standards we would expect of it.

**Bronchial Asthma**, by Leon Unger, M.D. (\$9.00. *Charles C. Thomas, Publ., Springfield, Ill.*) is a most excellent monograph which brings us up to date. Not only is it a book for allergists, but it belongs in the library of the internist and general practitioner.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

June, 1945

No. 6

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## Some Questions and Answers Concerning the Fenestration Operation

CHARLES E. KINNEY, M.D.

### 1. What is the Fenestration Operation?

It is a one-stage surgical procedure designed for the improvement of hearing in the type of deafness known as otosclerosis.

### 2. Does This Operation Cure the Disease of Otosclerosis?

No. When successful, the operation only reduces the severity of the main symptom of the disease, namely: the diminished hearing.

### 3. What is the History of This Operation?

The idea was first suggested by an Austrian doctor (Barany) and an English doctor (Jenkins) in the 1910's. In the 1920's and early 1930's a French doctor (Sourdille) and a Swedish doctor (Holmgren) performed the operation on human beings. Their operation consisted of from three to five procedures over a period of about two years. They could only maintain the improved hearing a matter of a few months in a relatively small percentage of cases. In the late 1930's, an American doctor (Lempert) improved the operation by making it a one-stage procedure and his results were much better than his predecessors.

### 4. Where Does the Operation Get Its Name?

Fenestra means window. In the human ear, there are two windows connecting the middle ear with the inner ear. One of these windows is round and the other is oval. They are about 1/32 of an inch in diameter. The round window is closed by a thin membrane. There are three small bones in the middle ear which transmit the sound waves from the ear drum to the inner ear. The third one of these three bones is called

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the stirrup, and the foot plate of this small bone fits into the oval window. In a goodly number of the cases of otosclerosis, new bone grows around this stirrup and does not permit the sound waves to be carried through the oval window into the inner ear as effectively as in a normal-hearing ear. In this operation, a new oval window is made into the inner ear in order that it can transmit the sound waves into the inner ear more effectively; hence, it is called the fenestration operation.

### 5. How Does One Know Whether His Deafness May Be Due to Otosclerosis?

Otosclerosis occurs approximately six times as frequently in women as it does in men. Quite often there is a history of some ancestor, even though it be two or three generations away, having had a similar condition. The rather typical case is as follows: The person begins to notice a gradual diminution of hearing in both ears some time between the ages of 16 and 35. Quite

often there is an associated ringing or buzzing in the ears; as the hearing loss progresses, this condition tends to diminish. The patient has never had earaches, nor has there been a discharge of pus from the ears. An examination of the ear drums reveal essentially normal ear drums. If the patient is a woman, in many instances, there is a history that pregnancies have made the hearing loss greater.

#### 6. Are All Cases of Otosclerosis Candidates for This Operation?

Definitely not. A complete examination of the patient's ears and a complete examination of his hearing on an audiometer must be made before this can be determined. The examination of the hearing must include an examination to determine how well the inner ear and the nerves leading from the inner ear are functioning. Before this operation can be considered, it must be established that the inner ear is functioning quite well.

#### 7. Is There Any Worthwhile Treatment for Otosclerosis?

No. Much research work has been done on this disease and many types of treatment have been advised, but none of these have any proven value.

#### 8. How Extensive is the Fenestration Operation?

It is an extremely delicate operation. The essential parts of this operation are performed under magnifying glasses. The patient stays in the hospital from twelve to fourteen days. The patient is dizzy from three to ten days, in some cases longer. For the first two weeks after he is released from the hospital, he must be seen and treated approximately three times a week. This means that the patient is off work about four weeks. The frequency of treatment diminishes thereafter until after the third month when he only need be seen about every six weeks.

#### 9. Is the Operation Done on Both Ears?

Never at the same time. If tests for the function of the inner ear give about the same response, which they usually do, the poorer hearing ear is always selected for the operation. If after one year from the first operation, the patient desires to have the other ear operated, this may be done.

#### 10. If a Case is Selected for This Operation, What are His Chances of Obtaining Good Hearing in the Operated Ear?

Eighty per cent of normal hearing, as determined by a puretone audiometer test and calculated by the approved American Medical Asso-

ciation method, is considered practical hearing. This means that a person with 80 per cent hearing in one ear usually considers himself to be a normal-hearing individual. Approximately 80 per cent of those persons having this operation have had their hearing restored to this practical level in the operated ear.

#### 11. If One's Hearing is Restored to This Practical Level Will it Remain There Permanently?

No one can speak about permanent results from this operation. This is a new operation and the oldest successful case is less than ten years old. In my experience, one out of every four persons obtaining practical hearing begin to lose their hearing about the fifth month, and by the eighth month, the hearing is back where it was before the operation. This is due to a bony closure of the new window and there is no way to predict which cases will close and which ones will remain open.

#### 12. If the Newly-Created Window Closes Can It Be Reopened?

Yes, this has been done but there is no assurance that it will stay open the second or even third time. There is little use in operating the same ear more than three times.

#### 13. What Happens to the Twenty Per Cent Whose Hearing Is not Restored to the Practical Level?

About one-third of these cases have improved hearing but not to the practical level. The second one-third of these cases have no change in their hearing. The other one-third have poorer or no hearing in that ear.

#### 14. Is the Hearing in the Unoperated Ear Ever Affected by the Operation?

No cases have been reported in which this has happened.

#### 15. Are There Any Serious Complications to This Operation?

In a recently combined report of the men doing this operation, which report included some 2200 cases, there were four cases of a paralysis of the face on the operated side and three cases of permanent dizziness. There were no deaths or other serious complications reported.

#### 16. Are There Any Age Limits to This Operation?

Age has nothing to do with the selection of a case for operation. However, it is only the occasional case of otosclerosis over 50 years of age that still has an inner ear which is functioning well enough to warrant operation and this never is found in a person over 60 years of age.



# Penicillin Therapy in Subacute Bacterial Endocarditis\*

S. A. HATFIELD, M.D., D. L. MAHANNA, M.D., and H. H. FERTMAN, M.D.

THE case histories of three patients in different stages of subacute bacterial endocarditis are presented for the purpose of demonstrating possible factors influencing the efficacy of penicillin therapy in this disease.

## CASE I

A 23 year old white married housewife, No. 442791, was admitted to the Urology Service of the University Hospital on April 4, 1944, with chief complaints of pain in the left side and temperature elevation of four weeks' duration.

This patient was in good health until six weeks prior to admission, at which time she developed a persistent non-productive cough and a lowgrade fever. Two weeks later the extraction of five abscessed teeth was followed by pain in the left flank and daily afternoon temperature elevations. Investigation by her private physician revealed that she had some albumin in her urine. Two weeks before admission she was hospitalized in another near-by institution, where continued fever, night sweats and albuminuria were noted. A diagnosis of "abscessed kidney" was made, and the patient was treated with urotropin and sulfonamides. She was then referred to the University Hospital for further urological study.

Past history revealed that this patient had had a severe episode of migratory joint pains at the age of nine, requiring bed rest for a three-month period. Subsequent evaluation of her cardiac status, including electrocardiography and roentgenologic study, showed the presence of valvular damage. In addition to this illness, the patient had suffered from repeated gingival abscesses and carious teeth.

On physical examination, a well-developed and well-nourished white female appearing her stated age of 23 years, was seen lying flat in bed in no acute distress. Her temperature was 100.4 F., pulse rate 90, respirations 30 per minute and her blood pressure was 116/60.

There was no evidence of petechiae in the skin or mucous membranes. Dental hygiene was poor with evidence of several extractions and numerous carious teeth. On dental consultation, it was found that the upper left and right first incisors contained devitalized pulp and were considered a source of infection.

The lung fields were clear to percussion and auscultation. Heart rhythm was regular. The point of maximum impulse was seen at the anterior axillary line and a diastolic thrill and murmur were present at the apex. A loud harsh systolic murmur, heard best at the apex, was found to be transmitted both to the axilla and to the left border of the sternum. A chest X-ray revealed hypertrophy of the left ventricle and a small amount of congestion in the lungs. An electrocardiogram on admission showed a heart rate of 110, notched P waves and a prolonged PR interval of 0.22 seconds. The QRS intervals were slurred, the St segments depressed in all

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leads, and the T waves were biphasic in the leads 1 and 4 and inverted in leads 2 and 3. Repeated electrocardiograms during and after penicillin therapy showed no essential changes.

A moderately tender spleen was palpated two fingerbreadths below the left costal margin. There was no enlargement of the liver nor any evidence of congestive heart failure.

On admission the red blood count was 3,050,000 with 9.5 gm. hemoglobin. The white blood count was 7150 cells with 78 per cent granulocytes, 20 per cent lymphocytes and 2 per cent monocytes. The urine sediment contained 8-10 white blood cells, 40-50 red blood cells and a few cellular casts per high power field. Blood urea nitrogen was 8.5 mg. per cent.

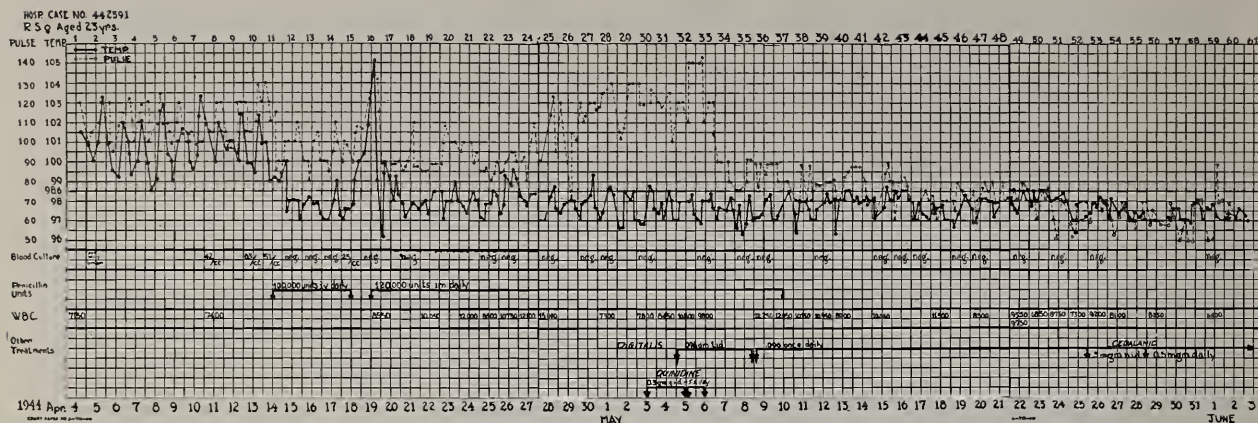
On completion of therapy the urine sediment contained 2-4 red blood cells and 0 white blood cells per high power field. Blood urea nitrogen was 14 mg. per cent. The red blood count at time of discharge was 3,740,000 with 11.2 gm. hemoglobin, and the white blood cells numbered 8,050 with 58 per cent granulocytes, 1 per cent metamyelocytes, 29 per cent lymphocytes, 10 per cent monocytes, and 2 per cent eosinophils.

A blood culture obtained shortly after admission showed 42 colonies of *Streptococcus viridans* per cc. Five other blood cultures drawn before penicillin therapy contained non-hemolytic streptococci, and the last of these showed 51 colonies per cc. Titration against standard doses of penicillin by the plate method revealed that the organisms were strongly inhibited by penicillin.

Prior to therapy this patient exhibited temperature fluctuations from 98.6 to 104 F. and a pulse rate of 110. Treatment with penicillin was initiated on the tenth hospital day. One hundred thousand Oxford units were administered daily in 3,000 cc. fluid by the intravenous continuous drip method. The temperature immediately dropped to normal and blood cultures became negative. Within 24 hours after institution of therapy, thrombophlebitis developed in each vein used. After five days of intravenous

\*From the Department of Medicine, Ohio State University College of Medicine. Submitted April, 1945.





therapy, the vessels were so severely thrombosed that intramuscular treatment, with 15,000 Oxford units of penicillin every three hours, was substituted with resulting remission of the thrombophlebitis.

Fifteen blood cultures obtained during the 25 days of therapy were all negative with the exception of one. The positive blood culture, containing 25 colonies of *Streptococcus viridans* per cc., was obtained on the fifth day of treatment and was associated with the only temperature elevation noted after institution of therapy. The temperature was 105 F., and there developed at that time an absolute irregularity of the pulse with an apical rate of 138 unaccompanied by any pulse deficit. Rapid digitalization was instituted.

On the eighth day of therapy the patient complained of severe sharp pain over the splenic area, requiring adhesive strapping and sedation for relief. On the fifteenth day of therapy a marked pulse deficit was found and quinidine was administered shortly thereafter in doses of 0.3 gm. four times daily. After nine doses, the pulse slowed to the normal range and fibrillation continued without pulse deficit. Clinically the patient improved markedly and penicillin treatment was discontinued after 25 days. Ten days later she was in a wheel chair and within another ten days she was permitted to walk about. Ten blood cultures obtained during a twenty-three-day interval subsequent to treatment were consistently negative. On the twenty-third day after penicillin therapy had been terminated, the patient was discharged.

Two weeks later she returned to the hospital for dental care under hospital supervision. Several dental extractions and fillings were accomplished while the patient was on adequate sulfadiazine medication. No exacerbations of symptoms occurred. Since then she has been moderately active at home and has been rechecked periodically. There has been no exacerbation of symptoms at this date, May 9, 1945, 13 months after penicillin therapy.

#### CASES II AND III. CONTRASTING RESULTS

Two other patients with subacute bacterial endocarditis, hospitalized at about the same time as the first patient discussed, failed to respond to penicillin therapy.

One of these, No. 440716, was a 23 year old white female with a history of repeated chills and fever following dental extractions eight

months prior to institution of penicillin therapy. At the time of admission this patient showed signs and symptoms of marked congestive heart failure, with pedal edema, orthopnea, dyspnoea and liver enlargement. There was present a coarse apical systolic murmur transmitted over the entire precordium. Petechiae were noted on the conjunctivae and the spleen was large and tender. This patient was moribund at the time penicillin became available to her and died within two days after treatment had been instituted. Blood cultures obtained during these two days remained positive for *Streptococcus viridans*, although *in vitro* studies had demonstrated that these organisms responded markedly to penicillin.

The other patient, No. 443658, was a 54 year old negro male who presented chief complaints of weight loss of nine months' duration and of weakness following an episode described as "flu". On admission this patient showed dyspnoea, orthopnea, pedal edema, and a large liver. His heart was enlarged and a loud coarse booming apical systolic murmur was present. On the seventh hospital day a few petechiae were noted for the first time on the left conjunctiva. Organisms obtained on blood culture were shown to be *Streptococcus viridans* and were found to respond moderately well *in vitro* to penicillin. Penicillin became available to this patient on his twenty-second hospital day. One hundred and twenty thousand Oxford units were administered daily for 21 days with only transitory sterilization of the blood stream and unsustained alleviation of temperature undulation. At the time this patient was sent home, on the forty-sixth hospital day, his blood culture was positive.

#### SUMMARY

A report of three patients with subacute bacterial endocarditis treated with penicillin is presented. Of these three, one patient has had a remission at present of 13 months' duration. In this patient symptoms of subacute bacterial endocarditis had been manifest for only six weeks prior to the institution of penicillin, and at no time was congestive heart failure evident. On the other hand, in two other patients in whom duration of symptoms of subacute bacterial endocarditis was present as much as eight and nine months, desired results were not obtained. Both of these latter patients were in congestive heart failure.



# The Practical Application of Quantitative Serologic Tests For Syphilis\*

ALFRED L. WEINER, M.D., and MARIE McNAMARA, A.B.

FOLLOWING the introduction of the complement fixation test for the serologic diagnosis of syphilis in 1906, the existence of different degrees of positivity was soon apparent. This phenomenon was also recognized with the subsequent development of the various flocculation technics of serodiagnosis and eventually led to the use of the "plus system" as a means of expressing varying degrees of positivity of syphilitic sera. Specimens giving a strongly positive reaction (i.e., containing relatively large amounts of reagin) were designated as "four plus" and those with lesser amounts of this substance\* as "three plus", "two plus" or "one plus". These facts are so well known as to seem superfluous, and yet there are serious deficiencies concerning the system which are not so generally recognized. Moreover, it may be stated that the complete significance of these differences in the positivity of syphilitic sera is not yet entirely understood and that too few clinicians possess a working knowledge of the known facts in this regard.

It has been established that the "plus system" is not truly quantitative or is at best only crudely so. Boas<sup>1</sup> in 1909 first demonstrated that separate syphilitic sera each giving "four plus" readings may contain vastly different quantities of reacting substance. This has been confirmed by many subsequent observers and more recently has been emphasized by Moore.<sup>2</sup> Moore and Eagle<sup>3</sup> and others have urged the abandonment of the outmoded "plus system" and have advocated expressing the results of serologic tests for syphilis as "positive" for sera containing sufficient reagin to produce complete flocculation or complete fixation (no hemolysis), "doubtful" for sera with partial fixation or flocculation, and "negative" for those with which these phenomena do not occur.

The American Committee on Evaluation of Serodiagnostic Tests for Syphilis has recommended reporting serologic reactions in this manner also. Many laboratories have been reticent to submit such reports but the more general adoption of this method for recording

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syphilo-serologic data would be of incalculable value to most busy clinicians who have neither the time nor the information necessary for the proper interpretation of a battery of confusing laboratory reports.

The true potency (amount of reagin) of syphilitic sera may be determined as in the Widal Reaction by quantitative titration of the sera, or indirectly by the addition of increasing quantities of complement to a constant quantity of serum and antigen. The former method is usually employed. Thus one can ascertain the reactivity of a given serum in various dilutions, (1:2, 1:4, 1:8, etc.) and the results may be expressed as units of reagin—designation being made according to the highest dilution which gives complete or virtually complete flocculation or fixation.\*\* Such quantitative serologic tests were first employed by Boas in 1909<sup>1</sup> and by Noguchi in 1911.<sup>4</sup> The Kolmer modification of the Wassermann reaction is a type of quantitatively titred complement fixation test. Quantitative treatment is applicable to any of the modern flocculation or complement fixation technics of serodiagnosis.

Clinical evaluation of quantitative serodiagnostic tests for syphilis has been studied by a number of investigators.<sup>5</sup> It has been found that these analyses are of definite significance in certain phases of serodiagnosis and syphilo-

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Submitted January 25, 1945.

\*Reagin may be defined as an antibody-like globulin which appears in the serum during the course of a syphilitic infection and which has the property of combining with finely divided particles of mammalian tissue lipoids.<sup>2</sup>

\*\*The highest dilution giving rise to a "two plus" (or stronger) reading, may arbitrarily be adopted as the "end point" in titration of a given serum.

therapy and of little or no use in certain other aspects. In any situation, a single quantitative test is of no value since the very nature of the procedure implies the use of repeated analyses over an interval of time if significant information is to be obtained. It should be noted also that a series of quantitative tests is comparable only when carried on by the same technic and in the same laboratory and that even then there is a factor of varying day by day sensitivity inherent within the laboratory and the test itself.<sup>6</sup>

The recent trends in the rapid treatment of (early) syphilis have stimulated interest in the use of quantitative serodiagnostic tests. It is the purpose of this report to present the practical aspects of the application of this technic in several types of clinical syphilis.

#### EARLY SYPHILIS

In primary, secondary and (very) early latent syphilis, quantitative serologic testing should be adopted as a routine procedure. Successful treatment of these types of syphilis demands serologic reversal and this can be accomplished with conventional treatment systems, under ideal conditions, in from 90 to 100 per cent of patients with primary and secondary syphilis, and in the majority of patients with early latent syphilis. Reports for early syphilis treated by the various forms of rapid therapy indicate that permanent serologic reversal takes place in from 80 to 85 per cent of patients. Most of these studies are necessarily of a preliminary nature however, and it is possible or even probable that the percentage of satisfactory results will eventually be even greater, particularly when cases which have relapsed and have then been retreated are included.

From two to eight months of treatment and/or observation are usually required for reversal of serologic tests with either method of treatment. In untreated primary syphilis, Crosby and Alexander found a gradual rise in the reagin content of the blood in the first four weeks.<sup>7</sup> The maximum titer was reached during the secondary stage where it remained approximately constant until the twenty-fifth week. After this there was a slow decline. These observations explain why it is not uncommon to see a rise in the amount of reagin in previously untreated primary syphilis following the initial injections. They also explain the consistent relationship of initial serologic titer to the duration of the infection in early syphilis and the observation that serologic titers are higher in secondary syphilis than in latent or tertiary forms.

It is evident that standard qualitative tests are of limited use in so far as they serve as an index of the rapidity with which serologic reversal occurs, whereas quantitative testing at frequent

intervals (weekly or every 2-3 weeks) enables one to follow the serologic trend with much greater accuracy. It has been found that the all important phenomenon, mucocutaneous relapse, can usually be anticipated prior to the appearance of the lesions, by a persistently maintained rise in the serologic titer. This knowledge is of tremendous practical importance since clinical relapse may often be forestalled where the serologic curve is unfavorable by the intensification of therapy or the use of different (arsphenamine, penicillin) antisyphilitic agents.

Quantitative serologic testing has been of inestimable value in following the progress of patients with early syphilis in the Venereal Disease Clinic of the Cincinnati General Hospital. During the past two years these patients have been treated by a modification of the Eagle method of intensified ambulatory therapy. Tri-weekly injections of mapharsen or phenarsine hydrochloride are administered for a total of 40 injections. Injections of bismuth subsalicylate are also given during the first 10 weeks so that about 13 weeks are required for completion of treatment. Quantitative sero-testing is performed at weekly intervals.

We have observed that initial serologic titers show decided variation depending on the duration and stage of the disease and that often there are considerable differences in the amounts of reacting substance among individuals whose infections, so far as could be determined from clinical and historical data, were of approximately the same duration. The titer has been lower in primary than in secondary syphilis and higher in patients with florid manifestations of secondary syphilis than in patients with minimal lesions. The rapidity with which serologic reversal occurs during treatment is in large measure dependent upon the degree of the initial titer, and thus reversal has taken place more rapidly in primary than in secondary syphilis and more rapidly in patients with fleeting and evanescent secondary eruptions than in those with severe manifestations.

These observations are in essential agreement with those reported from other clinics.<sup>7</sup> From two to eight months of treatment and/or observations are usually required for complete serologic reversal. Incidentally, our results with this type of rapid treatment have been almost uniformly satisfactory and there have been surprisingly few treatment reactions. Post-treatment observations of the clinical and serologic (blood and spinal fluid) status of these patients have embraced periods of more than one year in many instances.\*\*\*

Quantitative testing has also been employed in the follow-up examination of those patients treated by means of five day "massive drip"

\*\*\*Unpublished data.



therapy in the Cincinnati General Hospital and we have also relied upon the fall in serologic titer for evaluating treatment results in the relatively few syphilis cases thus far treated with penicillin. The eventual and optimum treatment of early syphilis has yet to be formulated but it will very probably include an arsenical, penicillin and bismuth. Some type of fever therapy may also be utilized. An accelerated schedule will undoubtedly be used so that more patients will complete their therapy and thus offset the ravages which result from irregular and incomplete treatment. Whatever plan evolves, it is certain that quantitative serologic testing will be an integral part of the method.

#### LATENT SYPHILIS—LATE SYPHILIS

In late latent syphilis and in late (tertiary) syphilis, the effects of treatment are measured in terms of clinical rather than serologic response. It has been demonstrated repeatedly that seroresistance is of no significance in late latent syphilis.<sup>8</sup> It should be emphasized again that where true latency has been established and where adequate treatment has been given, patients who are sero-resistant fare no better or worse than do those in whom serologic reversal has taken place. (The incidence of complications—development of tertiary lesions—is from 3 to 5 per cent in either group.) In large measure at least, this same lack of significance of seroresistance applies to most forms of tertiary syphilis since there is no evidence of any correlation among the degree of serologic positivity and the severity of clinical manifestation or pathologic change.<sup>9</sup>

With these facts in mind, it is apparent that quantitative testing is of limited or little value in late latent and in tertiary syphilis. However, it has been established that a progressive fall in the reagin content of the blood takes place over a period of years even in sero-resistant patients and even in untreated cases. Most clinicians are familiar with those patients with late or late latent syphilis who have received adequate antisyphilitic therapy and who are clinically free of syphilis but for whom seroresistance constitutes an important psychologic barrier. It is usually of little avail to explain to such individuals that there is no necessary relationship between the blood test and cure—that a sizable number of patients who are dying of cardiovascular syphilis or tabes for example, have negative blood tests. On the other hand, we have observed that a series of quantitative tests which reflects this decline in the reagin content over a period of months or years serves as a most valuable psychologic “lift” for such patients.

This type of follow up testing may also be an inducement which prevents lapse from essen-

tial post-treatment observations. Routine qualitative tests are usually too gross for the above stated purposes and for this reason quantitative testing can play a useful role in the management of patients with late latent and late syphilis.

#### CONGENITAL SYPHILIS

In early prenatal syphilis as in early acquired syphilis, quantitative serologic estimation can be applied as a means of determining the adequacy of treatment. Effective response in such cases implies serologic reversal and serial quantitative sero-testing serves as a measure of favorable or unfavorable therapeutic trends. For late latent and late congenital syphilis, the situation closely parallels that seen with the analogous forms of acquired syphilis. Here, although seroresistance is even more frequent and tenacious, its lack of significance is probably the same and quantitative serologic testing is therefore of little utility.

In the interpretation of serologic tests of the newborn children of syphilitic mothers, quantitative serologic testing can be applied to great advantage. When in these infants there are positive serologic tests for syphilis but neither clinical (nor roentgenologic) evidences of the disease, a diagnosis of syphilis is not justifiable. It has been found that these children are frequently non-syphilitic—that their positive tests are the result of the transfer, more or less passively, of maternal reagin. In such instances the reacting substance may persist in the blood of a normal infant up to three months. (It usually disappears by the end of the first month.) If the child is syphilitic, the reagin remains in his blood and usually increases in amount since it is presumably created by the infant's own tissues.\*\*\*\*

For these reasons, qualitative tests for syphilis are regarded as unreliable in the first months of life. In these situations serial quantitative testing is very useful. A progressively rising or maintained serologic titer indicates the probability of the eventual diagnosis of syphilis, whereas a progressive fall in titer would be indicative of the absence of syphilis. The accuracy of such serologic data has been recorded.<sup>2,9</sup> One should probably withhold treatment in cases of this type for at least one and probably for three months but even so the serologic curve is of considerable aid to the clinician called upon to clarify such an infant's status to the anxious parent.

#### DIAGNOSTIC PROBLEMS

The problem of suspected or actual false positive serologic tests for syphilis is a very real one for which there is as yet no conclusive or final answer. Exclusive of laboratory error, there

\*\*\*\*In some such infants the serologic tests may be negative at birth with the subsequent development of positive tests.



are numerous conditions known to be capable of giving rise to false positive tests and there are probably other circumstances of as yet undetermined nature, which may also produce this phenomenon. Serial quantitative testing is among the measures which have been advocated as an aid in the study of suspected false positive bloods.<sup>10</sup> These serums contain relatively small amounts of reacting substance in most instances so that characteristically, the reactions are weakly positive. On this basis alone the titer estimation may serve to strengthen or refute the supposition that the reaction of a given serum is falsely positive.

When, as is frequently the case, the underlying cause is of transient nature (fever, vaccination, infectious mononucleosis and other infections) the reagin decreases in amount or disappears rapidly. In patients with this type of reaction, quantitative testing enables one to follow the serologic trend more accurately than would be possible with the routine qualitative serodiagnostic technics. These tests are of little or limited utility however, where a less transient cause of the false positive reaction prevails. (Leprosy, yaws, malaria.)

#### SUMMARY

Quantitative serologic tests for syphilis have been found to be essential to the optimum treatment of early syphilis and useful in the management of latent and tertiary syphilis. They are also of value in the study of suspected false positive serologic reactions for syphilis and in the interpretation of the status of the newborn of syphilitic mothers.

Treatment failure—protracted seroresistance and clinical complications, especially neurosyphilis—among patients with early syphilis occurs predominantly in those who have experienced mucocutaneous relapse, a phenomenon usually preceded by a persistent rise in the serologic titer. Impending relapse which is thus detected by quantitative serologic tests can often be prevented by intensification or modification of the therapy which is being administered. The application of these principles to the management of early syphilis should materially increase the rate of curability of the disease and the routine adoption of the use of quantitative serologic procedures in early syphilis is urged. The more limited usefulness of these tests in other phases of syphilis has been discussed.

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### The Mechanism of Edema

Patients with glomerulonephritis frequently suffer from edema. This edema may occur in three different stages of the disease, and its mechanism is different in each stage. In acute glomerulonephritis the systemic capillaries are injured, their walls become more permeable and serum albumin escapes into the tissues where it holds water thus giving rise to edema. In the nephrotic stage the serum proteins become depleted as a result of loss of serum albumin in the urine. When the quantity of serum albumin in the plasma falls below a critical level, the normal balance between the hydrostatic pressure of the blood and the osmotic pressure of the plasma proteins is so disturbed that more water leaves the capillaries than returns to them and edema of the tissues results. Later, the nephrotic edema disappears spontaneously. This is not a sign of improvement because it is due to progressive destruction of glomeruli. In the very late stages of chronic glomerulonephritis, hypertension develops and cardiac edema may follow the onset of congestive heart failure. The edema of vascular nephropathy is due to congestive heart failure.—James P. Simonds, M.D., Chicago; The Illinois Med. Jr., Vol. 87, No. 3, March, 1945.



# Identical Twins: Achondroplastic Dwarfs

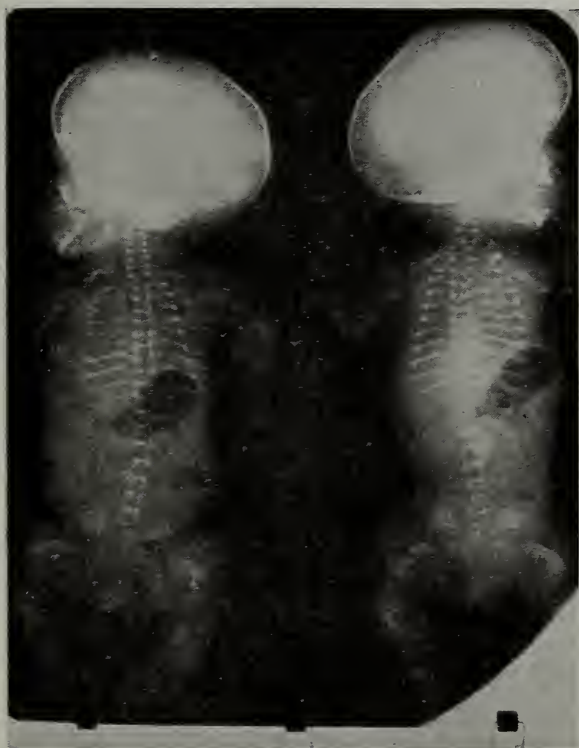
S. J. GOODMAN, M.D.

THE following is a report of the delivery of identical twins both of which were achondroplastic dwarfs. I am reporting this case as the first such report ever submitted. Inquiry of the American College of Surgeons brought the following answer:

"We have searched the Indices, Quarterly Index Medicus, from 1936 through March, 1944, and the Third and Fourth series of the Surgeon General's Index; but have found no case of identical twins, both being achondroplastic dwarfs. This, of course, judging the material only by the title."

They sent me reports of four cases in which only one twin was an achondroplastic twin.

On November 2, 1944, I was called by Dr. George Keil to deliver Mrs. R., of a footling



presentation. I found that there were twins. The first twin was easily delivered; the second was more difficult as version and extraction was necessary. Both twins were achondroplastic dwarfs.

Mrs. R. is 26 years of age; married 6 years; has borne two children; the last being two years of age. Both labors were normal. There is no history of any unusual illnesses of either mother or father of twins and all blood tests are negative. There have been several sets of twins, on the father's side, but none are known to have been abnormal. Both husband and wife are

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apparently in good health at this time. The mother's pelvis was X-rayed and found to be normal. The long bones were X-rayed and



found normal. Her other children are apparently normal.

The twins died after about four hours and no autopsy was performed as we saw no scientific reason for one.

Submitted December 23, 1944.

# A Review of Allergy

JONATHAN FORMAN, B.A., M.D., F.A.C.A.

THOSE who specialize in the field of allergy in those states which border on the Gulf of Mexico are confronted with an unusual type of "hay-fever" which these competent observers insist is an entity and is not caused by any of the known allergens responsible for allergic coryza. For several years now these physicians have bound themselves together in a cooperative search for this cause. In recent years, they have met annually to discuss "X hay-fever" and their progress in its investigation. Gradually reviews of the advances of allergy in other fields have been added to these annual meetings.

These physicians make a small closely knit society which can meet and indulge in informal round-the-table discussions of the main topics of allergy. Because they are a group of less than fifty, the U. S. Office of Defense Transportation gave them a permit this Spring to meet in New Orleans provided they would not use the local hotels over the week-end.

## BACTERIAL ALLERGY

The first round-the-table discussion was on "The Relation of Respiratory Infections to Allergic Problems". This discussion was initiated by a designated leader, Henry D. Ogden, M.D., of New Orleans and after all had taken a hand Allen G. Cozart, M.D., of Little Rock, Arkansas, attempted to coordinate what had been said upon this important subject. It was agreed that the subject needed much more study. All were agreed that the infection of the respiratory tract could precipitate an attack of allergic coryza and/or asthma. It, however, is the relationship of these two that is not clear. It would seem further to be agreed that it is not an atopic reaction for there are very few instances in which bacteria vaccines or extracts give an immediate (atopic) type of response to skin tests with them. Certain it is that they do give delayed responses not unlike those to tuberculin in properly sensitized persons. All, moreover, were willing to accept the tuberculin reaction as an example of the allergy infection (often called bacterial allergy). Then, too, Simon and Rackemann have shown that with certain antigens the immediate and delayed skin responses to testing are but different phases of the same allergic responses. Again, too frequently, there is no specificity in the skin responses to bacteria, according to a goodly number of observers. There are, however, as large a number of equally good observers who insist upon the specificity of their reactions.

So we get no full agreement as to whether there is a bacterial allergy at work in the par-

ticular case or whether the bacterial infection acts only as an aggravating factor in the production of an asthmatic attack. Children, older people, and those patients who give evidence of a marked imbalance of the autonomic nervous system react sharply to the weather and make it even more difficult to distinguish an "allergic cold" from an "infectious cold". It is true, however, that in respiratory allergics, we get a larger number of delayed skin reactions to bacteria. In these cases also we find more instances of sinusitis and a decidedly higher incidence (60 per cent) of infection of the nose and bronchi. In late life the bacteria are certainly of greater importance. All were agreed that X-rays of the sinuses were helpful in the diagnosis of these cases; more helpful than rhinoscopy, pharyngoscopy, transillumination although each of these have a necessary place in the study of the given case. Cytological studies as outlined by Hensel are indispensable and not too much emphasis must be placed upon the presence of a fever as it may be the result of either an infection or an allergy.

Bacterial cultures and smears yield different results in different hands. Most of those present placed the major emphasis on the staphylococcus aureus, a few on the pneumococcus, and more on the streptococcus. Vaccines apparently are used by all. But it would seem that these men were being weaned from the idea of using "any old bug to get a sore arm". It used to be felt by many of these same observers that it was the sore arm that helped and that the effect was entirely non-specific. This idea is passing.

Rhinologists tend to emphasize pus as the sine qua non of infection but it was pointed out in this discussion that hyperplastic membranes likewise in the sinuses were often as badly infected.

Drainage and local treatment, "sulpha" drugs, and vaccines are to be given a full trial and continued until the allergic management is successful in clearing up the underlying allergy before any surgical operation on the sinuses is undertaken. Usually it will not be necessary.

All of this brings to mind recent events. Perhaps we have accepted too readily the statement that the "common cold" was a virus infection. Two things stand out about virus infections: First, they give an immunity for six months or longer; second, that "sulpha" drugs are useless in their treatment. The administration of small doses of the sulpha drugs daily over a long period of time to large numbers of soldiers prevented "colds" almost completely. Furthermore, the patients whom we are talking



about with the ever-occurring colds exhibit only a fleeting immunity at best.

Brown of the Post-Graduate Hospital insists that it is the streptococcus, hemolyticus, which after infection transmutes itself into a streptococcus viridans and gets growing in the tissues, that is the important germ in the vast majority of cases. He looks upon it as the real cause of the common cold. He makes the point that all the other bacteria which we cultivate in our cultures are actually weeds in our bacterial garden. Certain it is that we have not the slightest bit of assurance that our vaccines have a single germ in them that is the cause of this infection which we are trying to treat. In fact, the chances are all against it being so. Brown reports excellent results with a filtrate of the streptococcus hemolyticus used in children over a period of years in conferring the temporary but badly needed immunity in these patients.

This viewpoint seems to your reporter to make sense out of this confusion. He uses bacteria for skin testing and finds them as reliable as any of his skin tests. He does not look upon the "reactors" as the cause of the infection but he does accept them as allergens in the case, and uses them in diluted graduated doses for hyposensitization, while he immunizes in the absence of positive skin tests to the streptococcus hemolyticus.

Your reporter realizes that this practice would not be accepted in its entirety by all who were present at the Southwest Forum on Allergy. Nevertheless, in practice, everyone seemed to be using the essentials of such a program even if he did not accept the reasons therefor.

#### ELECTROLYTES

Albert V. Stoesser, M.D., of the Department of Pediatrics of the University of Minnesota under the title of "Status Asthmaticus and Pitressen Therapy" presented the results of his 13 years' research upon asthma in which he has been trying to get at the metabolic changes which occur in an asthmatic child. His work has all been done on select cases, handled in the special metabolism ward in the University. All were atopic in type i.e., all had positive family histories, all had had eczema, all had had positive skin tests, all had had asthma for years, and all had physical changes in the chest. He and his associates have worked up completely 565 typical cases of atopic asthma and by the usual allergic management have obtained satisfactory results in all but 78 cases. Twenty-nine of these 78 failures were given further study. In studying these 29 cases in great detail it was found that glucose made them improve but that sodium chloride made these patients worse. With low salt diets and glucose the child underwent definite improvement. Injections of Pit-

ressin were used to keep a low salt content in the body of these children. It proved to be most successful in the control of the asthma. So it would seem that we physicians in private practice are the winner from this attempt on the part of these scientists to learn the physiology of asthma.

Your reporter wonders whether this salt acts directly or whether like an excess of calcium when applied to another balanced biological system, the soil, renders unavailable some essential trace elements.

#### NEUROSES

In these days, when one hears so much about "nerves", psychoneuroses, and psychosomatic medicine, it was refreshing indeed to hear someone take stock and present us with a critical appraisal of "Allergic Problems As Encountered by the Psychiatrist". This Coyne Campbell, M.D., the well known psychiatrist of the University of Oklahoma, did for us at this meeting. He again pointed out that the new term psychosomatic medicine in itself denies the unity of man and makes of him two separate parts, the mind and the body. These moderns, it is true, do attempt to correlate the two and emphasize their interdependence. But there are not two parts to a man. His mental and emotional responses all are but a function of his nervous system just as his digestion is a function of his alimentary system. The skilled clinician has always recognized how dysfunction of the nervous system has a baneful influence upon the rest of the body. He, however, never spent his valuable time digging into the dirt of his patient's past. What he can remedy he remedies without that. Glorifying in the forbidden with the patient may be a pleasure for dirty minds but it never cures allergies. At its worst dysfunction of the nervous system is only an precipitating factor and can not operate unless there is the allergic state to aggravate or precipitate. This paper is of such fundamental importance to general practice that we hope to publish it in full in this *Journal*. It is scheduled to appear in the *Annals of Allergy* as are most of the papers presented at this meeting.

#### HIVES

This reporter has always insisted that pragmatically it is wise to consider all cases of nettle-rash, bold hives, angioneurotic edema, as due to some form of allergy. It was with this in mind that I began the discussion on urticaria. Urticaria may be a lesion resulting from any one of the various types of allergy, viz:

- A. Atopy. With or without positive skin tests, usually without.
- B. Non-Atopic Allergy:
  1. Non-reaginic familial allergy (coca).

2. The allergy of infection (bacterial allergy).
3. Chemical allergy (drug allergy).
4. Serum sickness.
5. Contact allergy.
6. Physical allergy.

By a carefully taken history, the type of allergy at the bottom of the trouble can usually be pretty accurately surmised.

As is always the case, most of the discussion centered around the precipitating factors. Those factors which in themselves can not cause trouble but which may seem to bring out what otherwise would remain a latent allergic state. In other words, they may upset the balance in favor of allergic manifestation in an allergic patient who, up to the time when they became operative, was in a state of "allergic balance" (as Vaughn called it) and free of symptoms. Among such predisposing factors are:

1. Barometric Changes.
2. Temperature Changes.
3. Light.
4. Emotional Upsets and Anxiety.
5. Fatigue.
6. Focal Infections.
7. Acute and Chronic Infections.
8. Constipation.
9. Deficiencies:
  - a. General malnutrition.
  - b. Specific vitamin deficiencies.
  - c. Mineral deficiencies.
  - d. Deficiency of gastric juice:
    - (1) Hypochlorhydria.
    - (2) Achlorhydria.
  - e. Liver insufficiency and dysfunction.
10. Mechanical and Chemical Irritation.

Our method of management offers nothing new but does place great emphasis upon being systematic in the approach so that few cases can escape through this diagnostic net or fail to get the relief to which these victims are entitled. Hence at the very first visit we test for the foods which we may wish to use in our elimination diets and for the 25 common bacteria. Careful investigation is made into the possible exposure to chemicals (drugs) and for possible foci of infection. All contacts with chemical and the use of all drugs is forbidden. The patient is placed upon an elimination diet, preferably only the products of wheat and milk (Forman), or it may be rice, fruit, sugar (Kempner), or beef, rice, and pears (Alvarez), or one of Dr. Rowe's more elaborate diets. Attention is given to the control of all recognized infections.

Of the non-specific aids in treatment, we use histamine in graduated daily doses subcutaneously and feel that it helps. We are frankly afraid of Hepamine. Where we can find evidence

of the presence of any of the predisposing factors already mentioned, every effort is made to correct them. Last Fall, at the New York meeting of the American Academy of Allergy, J. Harvey Black of Dallas, Texas, presented his excellent results with vitamin K in the treatments of urticaria in which there was a prothrombin deficiency. In opening the discussion on that paper your reporter expresses the belief that Dr. Black with his vitamin K and bile salts was correcting a dysfunction of the liver and where such existed he was bound to have improvement in the case for the liver has to do the big job of detoxification in every allergy reaction. Internists have emphasized the role of the liver in these conditions for a long time but we allergists have been unmindful of their importance.

#### MIGRAINE

One of the most painstaking students of food allergy is Herbert J. Rinkel, M.D., of Kansas City who led a round-the-table discussion on Migraine at this meeting. His careful testing of one food after another by feeding that food in his office and watching the results after the food had been eliminated from the diet some days before the test has been described in a recent number of the *Annals of Allergy*. This technique seems so complicated and time-consuming that, while Dr. Rinkel always draws huge crowds of enthusiastic listeners whenever he appears on a program, nevertheless, few have the strength to try his system when they get back home. Rinkel pointed out that following Vaughn's paper some years ago in which it was shown that migraine could be an expression of allergy and often was due to food allergy, a dozen or more of us including Rinkel and your reporter presented papers confirming these observations.

Then interest died down and except for the regular study groups on the program of the Annual Forums On Allergy little or nothing has been heard on the subject. In fact, recent publications on migraine by prominent neurologists have failed to mention allergy as a possible cause. More interest, Rinkel insisted, ought to be shown on this important phase of the problem of headaches. Allergic migraine, he said, was usually atopic or "non-reaginic familial" in type and was as a rule due to foods. When in rare instances it is due to sensitization to an inhalant it is usually accompanied by nasal symptoms. For details the reader is referred again to Rinkel's article in *Annals of Allergy*. He is convinced that the negative results reported in the literature are absolutely worthless. They are worthless because of the haphazard manner in which the studies have been carried on. Certainly interest in this subject should be aroused again for our patients can actually be relieved by meticulous attention to details.



## FUNGI

Most of the members of the Southwest Forum on Allergy are members of the American Society of Allergists for Mycological Investigation and so the round-table led by Homer Prince, M.D., of Houston, Texas, was the high light of the program. Prince pointed out that while all were agreed that mold spores are capable of sensitizing individuals and producing allergic symptoms, there were great difficulties in getting the subject of "Mold Allergy" on a practical working basis. Among these difficulties are (1) The almost unlimited number of species; (2) the difficulty in culturing them, especially the rusts and smuts; and (3) the difficulty in making biologically active (antigenic) extracts. He pointed out that some molds worked inside the body and some outside of the body. Of those working inside of the body, trichophyton and monilia are examples. Of those coming from without are the myriads of fungi some of which have formed the basis of the researches of the cooperating group.

B. G. Efron, M.D., New Orleans, in trying to sum up what had been said, pointed out that the subject of mycology itself was still chaotic. There was no regular method of classification. Classifications, therefore, are not in agreement and so it does no good to accept them. One had better grow his molds, number them, and use them for testing and treating without attempting to classify them or name them: if they prove antigenic, keep them; if not, throw them away. All of this means that this field is going to call for a great deal of research for a long time to come. In the meantime, it seems to your reporter that it will be every man for himself and this means a lot of discussion, a lot of speeches, a lot of misunderstandings, and a lot of publication, with papers of more misunderstanding than knowledge. Such is the progress of man!

## THE WEATHER

At the dinner meeting William F. Petersen, M.D., of Chicago spoke on "The Response of Man to His Environment" and again the next morning on "Weather as it Affects the Normal and the Allergic Individual". Petersen's carefully done researches show how all our bodily functions move in rhythm with nature. As our environment shifts from warm to cold, from cold to warm, from dry to wet, and back again so must our bodies make vaso-motor responses and chemical shifts of considerable magnitude. To all of these the allergic individual is hyper-responsive and will be hypersensitive even though his allergy is controlled by one means or another.

Hence, the response of our patient to our therapy may vary to a remarkable degree. Such changes may be the result of changes in the

weather and its resultant reduced energy threshold, just as readily as by reduction of the threshold through nervous or endocrine means. No matter how well the patient may have been doing, irritated or damaged cells do not forget and so often it takes but a little shift to start the patient's trouble on a rampage and set the physician to wondering what has happened to his patient. Instead of an obvious approach, which Dr. Petersen pointed out is very simple, in allowing the patient to build up collateral and body regeneration so that such changes can be met, the allergist is too apt to begin to wonder if his extracts are potent and piles in sedatives and increases the frequency of his vaso-constricting drugs.

To all, but to the allergic especially, this means when cold put on warm things, when warm take them off, and above all when tired, rest. Do not go against the weather!

Once long ago at Atlantic City before the old Eastern and Western Societies, last Winter at the Sixth Annual Forum On Allergy at Pittsburgh, and now at the Southwest Forum in New Orleans, Dr. Petersen has pointed out to the allergists of America these very important observations and it is a pleasure to report that allergists are beginning to understand their significance

## ALLERGY OF THE SKIN

Dr. Louis A. Brunsting of the Mayo Clinic, brother of our own Dr. Henry A. Brunsting of Toledo, who was visiting his brother while at this meeting, gave an excellent résumé of atopic eczema and contact dermatitis. Atopic eczema, he said, with its flexure eczema of children and its neurodermatitis of adults is amenable to skin testing and allergic management. In contact dermatitis patch testing is most helpful if intelligently carried out.

Dr. Brunsting pointed out how important contact dermatitis has become due to the introduction of so many new allergens in the occupations, especially in defense industries. With these exposures some skins seem to harden finally and become resistant while others become worse. We must not forget that we, or the physicians ahead of us, may have made the patient worse with a resorcin, mercury or "sulpha" ointment as these are all great skin sensitizers.

In the selection of testing material it is not always safe to test with an obvious cause. Occasionally we may purposely re-expose the patient just to prove the facts to all concerned. As an example, in girdle dermatitis it is not necessary to test the patient. On the other hand, it may become necessary to ask her to wear the garment again just to prove what is obvious. The first principle of treatment is to separate the patient from his exposure, including his medication.

With atopic eczema, physicians, allergists, and dermatologists alike have many a headache. When skin tests are positive they may be of more historical interest than help in meeting the problem which confronts us. All seemed to agree with him that under no circumstances should the patient be given a lot of skin tests and allowed to go away with the impression that he was allergic to any or all of these or that he is not at all allergic to those things which gave a negative skin test. On the one hand severe nutritional deficiencies may develop months or even years later. While, on the other hand, the eczema may go merrily on its way while the patient continues to eat food to which he is allergic. There are many complications among which Dr. Brusting mentioned vitiligo, alopecia areata and cataract. Your reporter recently emphasized the relationship between cataract and atopic eczema in *The Letters*. This cataract is of a particular type and can be differentiated from other types by the ophthalmologist.

Another complication is Kaposi's Varicelloform eruption (eczema vaccinata) which is fatal in about 15 per cent of instances. Dr. Brusting looks upon it as a virgin infection. (At any rate one can recognize its danger as well as the danger of vaccinating persons with a dermatitis and the necessity of protecting patients with eczema from exposure to vaccina if they are not immune. Several cases to the point have recently appeared in the literature.

The management of eczema, cause, and control of insomnia where fatigue exists is a program of moderation and great care not to overuse the eyes.

Dr. Pearl Zink of San Antonio, Texas, neatly summarized this round-table and its discussion.

#### SKIN TESTING

As is usually the case skin testing came in for a rather complete discussion. Frederick Wittich, secretary of the American College of Allergists, led the discussion. He went into much technical detail, emphasizing the state of the skin. He pointed out that the skin should be warm and bared in a warm room and suggested that in the prone condition the blood supply to the skin is best. Furthermore, Dr. Wittich said the skin of the back is more sensitive than that of the arm, and the upper back more responsive than that of the lower back. Skin varies in its response from day to day so Dr. Wittich insists that all positive tests should be checked two or three times before being accepted as positive. The doctor also insists that in case of negative tests reagents disappear from the skin if a food is not eaten for three or four weeks.

The best time to test is when the patient is free of symptoms. Dr. Wittich warns against testing after the use of drugs; of doing too many

tests at one time; finally, the nature of testing substances should be considered, its irritating qualities, its histamine content and the dilutant employed are important. The doctor insisted that one should have clean tests, made with clean instruments and clean glassware. In conclusion, the doctor advised very strongly that boiling does not destroy the antigenic properties of a testing material so that all glassware and syringes must be clean chemically and mechanically. In fairness it should be said that there was not general agreement about all of these precautions. They may be fastidious but certainly when followed there could be little to criticize about the methods of testing.

#### THE USE OF X-RAY

After a recess the meeting came to order under the leadership of L. O. Dutton, M.D., of El Paso, Texas, who reported on the work that he and Richard Fuchlow, M.D., roentgenologist, had been doing on "Sino-Bronchial Syndrome Complicating Atopic Asthma in Children and Its Treatment by Roentgen Ray." Their results were summarized by them on mimeograph sheets which they gave to the reporters and we reproduce here:

1. The usual allergy investigation and management fails to diagnose all factors or control all symptoms in some asthmatic children:

a. Evidenced by symptoms which occur in children who are under apparently adequate management and for which no atopic etiology is demonstrable.

2. The sino-bronchial syndrome may be identified in some children as one non-atopic factor in production of otherwise unexplained symptoms:

a. Symptoms of sino-bronchial syndrome as they occur in the allergic asthmatic child. Rhinitis, post-nasal drainage, cough, fever, wheezing. Duration four days to two weeks. Patient appears sick.

b. Physical findings: Breath sounds resemble those of bronchitis more than the asthmatic. May or may not have rales. Pulse rapid. Fever. Not strikingly different from physical findings in usual asthmatic attack.

3. Laboratory data: Nasal smears of importance. Neutrophilic, bacteria usually numerous, either streptococcus, pneumococcus, or staphylococcus. May require serial smears to find significant elements. Blood count usually indicates some inflammatory process. Sedimentation rate usually more rapid than in strictly allergic attack. Sputum examination usually shows predominance of streptococcus, pneumococcus, or staphylococcus. Numerous neutrophils present. Only occasional eosinophile present.

4. X-ray data:

Chest. Exaggerated peribronchial thickening with coalescence of hilar shadow.



Sinuses. Hyperplastic membranes. To be made in interval phase.

- 5. This whole series of changes tends to be chronic; producing residual symptoms of mild character between acute attacks.
- 6. Response to usual treatment. Poor response to adrenalin or ephedrine during acute attacks. Good response to chemo-therapy. Fails to respond to allergic management.
- 7. X-ray treatment of sino-bronchial infection. Indications: Well established diagnosis. Treatment carried out in chronic phase. Technic varies—about 400 R units over sinuses and chest in three to five treatments at 48-hour intervals.

Response: Frequently an initial improvement. Reaction of increased nasal congestion at second week. Gradual improvement of entire picture.

Results: Generally good. Patients have fever "colds". May have "colds" without the usual accompanying asthmatic attack, general health improves, appetite improves, gains weight.

Follow-up X-ray studies should be made in six weeks following treatment. Often see striking improvement in chest and sinus findings.

- 8. Summary: We may emphasize:
  - a. Many asthmatic children are not well controlled by allergic management.
  - b. Some of these present the sino-bronchial syndrome. Acute attacks with residual chronic symptoms.
  - c. This diagnosis can only be made by careful observation. Serial laboratory and X-ray studies. Failure of allergic management.
  - d. X-ray treatment offers a safe convenient means of favorably influencing the course of this syndrome.

DIFFERENTIAL DIAGNOSIS

|                      | Allergic Asthma                                     | Sino-Bronchial Syndrome            |
|----------------------|-----------------------------------------------------|------------------------------------|
| Onset                | Eczema H. F. Asthma and Rail                        | Asthma begins with cold            |
| Duration of attacks  | Proxysmal short duration                            | Gradually developing long duration |
| Fever                | Not usual                                           | Usual                              |
| Response to Adrenlin | Good                                                | Poor                               |
| Leukocytosis         | Infrequent                                          | Frequent—mild                      |
| Nasal Smears         | Eosinophilic                                        | Neutrophilic                       |
| X-ray Chest          | Minimal changes                                     | Striking changes                   |
| X-ray Sinus          | Minimal changes                                     | Striking changes                   |
| Sedimentation        | Very slow                                           | Frequent—mild                      |
| Bacteriology         | Indifferent                                         | Usually strep. pneumo. or staph.   |
| Seasonal Incidence   | Either not seasonal or corresponds to pollen season | Winter or change of season         |

In the discussion Dr. Stoesser pointed out that these were the same kind of asthmatic children that he had been using his Pitressin therapy on in Minneapolis. He expressed the belief that the climate in Southwest Texas was the cause of the somewhat milder symptoms of these chil-

dren so that they might well be handled by the use of X-ray. All were agreed that it would be a sad mistake if the impression got around that X-ray was the treatment of choice. It can not be emphasized too strongly that this type of treatments it to be reserved for this special type of case.

At the two luncheons a host of miscellaneous subjects were taken up and discussed briefly. Good results and bad results were reported for Hepamine. Histamine had good words spoken for it. It was agreed that when there were vitamin deficiencies the results obtained from allergy management were better when such deficiencies were controlled but that the use of vitamins as drugs in the treatment of allergy patients had not proven helpful. Aminophyllyn was highly recommended especially when used intravenously or in rectal suppositories if used in large enough doses. Ten grains was the recommended dose for suppositories. There was no dissension to the statement that five grains was not enough. Your reporter in recent months has made extensive use of these suppositories and has had always uniformly good results with 7½ grains. Certainly there is nothing that gives the patient more relief and makes it unnecessary to use hypodermics or adrenalin. "Sulpha" drugs and penicillin both were given a place in the control of complicating infection but we were warned that all were drugs to which our patients could readily become sensitized. Especially were ointment and chewing gum containing "sulpha drugs" condemned. Trichophytin and oidio-mycin, as brought forward by Marion Sulzberger, had success and failure reported for their use. It would appear that they are real helpful but in a limited way.

The warning was again issued that occasionally severe allergic reactions with extensive exacerbation of the dermatitis may occur from the use of these injections so that caution should always be employed as to the initial dose. Paul Flemming, M. D., of Houston, Texas, gave a sane presentation of the management of pollenosis emphasizing the systematic care of the patient, nursing practices, and hygienic control. With these he insisted that the results would always be excellent and the number of failures minimal. He condemned "the needle pushing" method of treating a patient with hay fever.

These Southern and Southwestern physicians are to be congratulated upon their excellent program. What every field of medicine needs is more of such meetings where everyone "let's his hair down and tells the truth" instead of those where each of us attempt to impress the rest with his erudition. Good clinical meetings are those where all can jump in with whatever question or contribution they have. Next year this group meets in Houston, Texas.

# On the Management of Addison's Disease

E. PERRY McCULLAGH, M.D., and R. W. SCHNEIDER, M.D.

INCREASING familiarity with the effect of adrenal hormones has led to important changes in the treatment of Addison's disease.<sup>1</sup> Until ideal treatment is attained, it is worth while from time to time to review, criticize, and evaluate methods of treatment. Accurate diagnosis is essential, and here new laboratory tests are of great assistance. The water excretion test has proved extremely helpful, chiefly because it is so readily available.<sup>2</sup> The more complex Wilder test<sup>3</sup> of chloride excretion settles difficult differential diagnoses in most cases.

Urinary 17-ketosteroid levels are usually<sup>4</sup> but not always low<sup>5</sup> in men with Addison's disease. Having neither testis tissue nor in Addison's disease healthy adrenal cortices, women are likely to show very low levels of urinary 17-ketosteroids. For these reasons a test for urinary 17-ketosteroid excretion is an adjunct of some value in the diagnosis of adrenal cortical failure. The level may be low in some women in apparently good health. The effect of ill health upon the test must be taken into consideration in all cases. Also a thorough investigation should be made for infection, especially for tuberculosis.

The aim of therapy is to reproduce normal health by overcoming weakness, anorexia, digestive disturbances, abnormal loss of sodium chloride and water and retention of potassium and urea and by regulating unbalanced carbohydrate and protein metabolism. Four methods of treatment are generally available.

1. Diet.
2. Sodium chloride.
3. Adrenal cortical extract.
4. Desoxycorticosterone acetate.

## GENERAL CONSIDERATIONS

The diet should be high in carbohydrates. Frequent feedings are necessary to prevent hypoglycemia, which might prove fatal. A relatively high protein intake is also desirable, and an attempt should be made to maintain a caloric intake high enough to overcome weight loss. A relatively high intake of vitamins B and C is desirable. The potassium intake should never be restricted when desoxycorticosterone is being used. A low potassium diet may be useful when a combination of diet, salt, and adrenal cortical extract is used.<sup>6</sup> Low blood potassium levels may be associated with abnormalities indicated by the

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electrocardiogram and by changes in the heart muscle.<sup>7,8,9,10</sup>

Sodium chloride may be given orally as "Addison's Elixir".<sup>11</sup> We prefer 1 gm. enteric coated tablets and prescribe doses varying from 3 to 12 gm. per day. Usually 3 to 6 gm. is adequate. Ten grams per day is approximately equivalent to 1 mg. of desoxycorticosterone by injection, but the effect is more transient.

Adrenal cortical extracts provide the most complete type of replacement therapy and supply hormones that affect not only sodium chloride and water metabolism but carbohydrate and protein metabolism as well.\* Such extracts may be used to advantage in conjunction with desoxycorticosterone. Extracts are available for oral and parenteral use. However, there is little evidence that oral extracts have clinical value, since the best tablets provide one-fortieth to one-sixtieth the amount of whole gland equivalent present in 5 cc. of extract for parenteral injection. Extracts for oral use are not biologically assayed.

Desoxycorticosterone administered orally has been carefully evaluated and is less than one-fifth as active as when used parenterally. This may or may not be true of extracts. If it is, 5 cc. of extract given parenterally is almost equivalent to 250 tablets taken orally. In the opinion of most experienced clinicians 5 cc. of a commercial extract is less than an adequate daily dose, although Rogoff<sup>12</sup> claims prolongation of life in patients treated orally. Certainly when adrenal cortical extract is needed, it can be provided most efficiently by injection.

\*Such extracts are produced by Wilson, Upjohn, and Parke, Davis and Co.



It is difficult to compare the strength of various extracts accurately because of differences in methods of standardization, which are based on various actions of the cortical hormones. For similar reasons it is impossible to make an adequate comparison between various aqueous extracts and steroid hormones used orally. As Goldzieher<sup>13</sup> points out, "potent fractions of the cortex exist in the gland in their aqueous phase", and that certain "amorphous fractions are active in some respects in relatively minute amounts".

At the present time extracts used clinically should contain at least 50 dog units<sup>14</sup> per cc. or should be equivalent to 40 to 70 gm. of gland per 1.0 cc. of extract. When extract is the only therapy used, much more than 5 cc. per day may be necessary. Thompson<sup>15</sup> uses 15 cc. or more per day. Such treatment, supplying 5 cc. of extract, or 250 dog units per day, costs approximately \$60 per month. Early work on hog adrenal extract in oil<sup>16,17</sup> indicates the possibility of a more potent material with greater effect on carbohydrate metabolism. Of six cases treated with hog adrenal extract two showed more improvement than those treated with large amounts of aqueous adrenal cortical extract in addition to pellet implantation.

#### DESOXYCORTICOSTERONE

Desoxycorticosterone may be given orally in tablets or sublingually in tablets<sup>18</sup> or in solution; it may be injected in oil or implanted subcutaneously as pellets.<sup>19</sup> The effectiveness of a given dose varies considerably with the method of administration: The oral dose is less effective than the sublingual dose; the sublingual dose is approximately one-fifth as potent as the injected dose; and the dose injected in oil is perhaps one-half as effective as that absorbed from pellets.

Desoxycorticosterone is used to prevent excessive excretion of sodium chloride and water and to promote excretion of potassium. The tendency has been to use too large a dose. When severe cortical deficiency exists, when plasma proteins are very low, or when severe anemia is present, the danger of hemodilution is often exaggerated. Large doses of desoxycorticosterone may be not only useless but dangerous, when electrolytes and hematocrit readings are returned to normal. Other hormones may be added to the treatment to provide a more complete physiologic response if needed. Desoxycorticosterone is available in oil in a potency of 5 mg. per cc.\* A dose of 2 to 3 mg. per day is usually adequate for maintenance. Such therapy costs approximately \$10 to \$15 per month.

Desoxycorticosterone pellets have recently become generally available. We have used 75 mg. cylindroids,\*\* which supply approximately 1 mg. per day for each 300 mg. implanted. Other types of pellets may be absorbed at different rates. Thorn<sup>1</sup> used discoid pellets weighing approximately 125 mg.\*\*\* The cost of therapy with cylindroids supplying 1.5 mg. per day and discarded in nine months is approximately \$8 per month.

Desoxycorticosterone provides little or no protection against the infection or crisis and little if any against hypoglycemia. Until better preparations are synthesized, the best available protection in case of infection or crisis is provided by potent extracts.

Testosterone has been suggested as an adjunct to treatment.<sup>20,21</sup> Since a low level of urinary 17-ketosteroids does not necessarily indicate testosterone deficiency, the value of prescribing the androgen remains to be proved. Treatment will probably be considerably more effective when other substances having an adequate effect upon carbohydrate and protein metabolism, such as corticosterone, are available.

#### TREATMENT

We believe that the best available treatment for Addison's disease at present is a combination of pellets and adrenal cortical extract and careful attention to the diet. The treatment differs under varying circumstances. The methods of treatment which we have followed recently are applied to three groups of cases: (1) uncomplicated cases, (2) those in crisis which have not been under treatment, and (3) those in crisis with desoxycorticosterone implants.

1. Uncomplicated case. The patient is usually hospitalized and, if not very ill, is allowed to be about the room. Six gm. of sodium chloride as enteric coated tablets and approximately 3 mg. of desoxycorticosterone in oil are given daily. Frequently the patient who has been ill for many months does not show a complete response to treatment for a number of weeks.

The diet is not restricted but should be weighed for a careful record of caloric intake, unless such manipulation limits the choice or amount of food taken. Food is given between meals and at bedtime. Nourishment is left on the bedside table, and the patient is instructed to take it upon waking. No adrenal cortical extract is given up to this time.

In the initial phase of treatment the object is to compute the minimum dose of desoxycorticosterone acetate that produces the optimum effect and maintains normal hydration. To help

\*Cortate-Schering; Percorten-Ciba, Doca-Roche-Organon.

\*\*Some kindly supplied by Schering Corp.; some made in our own laboratory by Dr. Lena Lewis.

\*\*\*Ciba and Co.

determine this, the blood pressure under basal conditions and the weight before breakfast are obtained each morning. Edema and rapid weight gain indicate overdosage. Overdosage is not likely to be reflected in arterial hypertension in less than four to six weeks. The blood plasma sodium and potassium levels, as an index of hormone effects, are measured if possible every two or three days. In some instances serum calcium levels are helpful in calculating hydration of the blood, since normally they are constant. Serum calcium levels may be low, however, if the plasma protein level is reduced. The dosages of desoxycorticosterone and salt are governed by these clinical and laboratory data.

After one or two weeks the patient leaves the hospital with instructions to take daily doses of desoxycorticosterone and salt. Reexamination is made as often as seems advisable. At the end of four to six weeks the weight, blood pressure, blood count, and hematocrit level, and usually blood chloride and potassium levels are measured, and the degree of hydration is reappraised. From this information the maintenance dose of desoxycorticosterone and salt can be fairly accurately estimated, and pellets can be implanted. The pellets are designed to supply one-half the average daily dose required by injection. We have been using pellets with an absorption rate of approximately 1 mg. per day for each 300 mg. implanted.

For example, a given patient is well maintained for the first six weeks of treatment on 6 gm. per day of sodium chloride and 5 mg. of desoxycorticosterone three times per week. This represents an average daily dose of 2.14 mg. The amount of absorption from pellets is calculated as 1.1 mg. daily. Therefore, the amount to be implanted is 300 mg., or four 75 mg. pellets. We expect such pellets to last eight months to one year. After pellet implantation salt is not given unless necessary to maintain weight, blood pressure, hematocrit level, and a general sense of well-being. When muscle aching, hypoglycemia, or other symptoms indicate that desoxycorticosterone and salt alone are not sufficient, adrenal cortical extract is given in doses of 2.5 to 7.5 cc. per day.

The patient is warned against overexertion. He is given written instructions for handling an emergency such as infection or crisis and is asked to obtain an emergency kit to keep at home, especially if he lives any distance from a hospital. The emergency kit contains:

1. Two thousand cc. with 10 per cent glucose\* of Ringer's solution or normal saline solution with 10 per cent glucose.\*\*

2. Appropriate rubber tubing and intravenous needles.\*\*\*

3. Fifty cc. of suitable adrenal cortical extract.
4. Ten cc. of desoxycorticosterone in oil, each cc. containing 5 mg.
5. Twenty sulfathiazole tablets of 7.5 gr. each.
6. One hundred 1 gm., enteric coated sodium chloride tablets.

The patient is warned that diarrhea, excessive sweating, vomiting, and other conditions leading to chloride loss may precipitate a crisis. If extreme weakness or drowsiness occurs at any time, the patient is advised to call his physician or to go to the hospital.

If no complications arise, the patient is seen at intervals of one to two months when a minimum of reexamination includes interval history, weight, blood pressure, and a careful red cell count and hematocrit readings. We prefer to have in addition a record of blood sugar, chloride, and potassium. A low serum potassium level is an index of considerable desoxycorticosterone overdosage. Within six months of pellet implantation salt intake may be varied as needed or adrenal cortical extract given. After eight months replacement of pellets is considered.

When symptoms begin to recur, when blood pressure begins to fall, or when weight is lost, the old pellets are removed and other pellets implanted. Toward the end of the life of the pellets the patient should be carefully watched for evidences of deficiency. After showing marked improvement for many months, a patient may be close to serious deficiency without showing evidence of it. Accordingly, the physician should not be tempted to depend upon the pellets for too long.

In most cases desoxycorticosterone requirements are not reestimated by a new course of injections, but an attempt is made to duplicate absorption, as judged by the time during the life of the pellets when the patient was in the best health. In nearly every case treated thus far less desoxycorticosterone has been implanted on the second or third occasion than on the first. At present we are using doses smaller than those of a year or more ago.

2. Cases in crisis previously untreated by pellet implantation. With the least possible delay the patient is put to bed in a private room. He is kept warm and is examined only for serious infection; in extremis even this is omitted until treatment is begun. It is well to realize that mild leukocytosis and relatively high fever not infrequently accompany adrenal crisis and do not necessarily indicate infection.

A blood sample is obtained for tests as outlined previously. Intravenous administration of a 1 per cent saline and 10 per cent glucose solution is started immediately; 1000 cc. is given rapidly, and the same amount is given slowly four hours later. Ten cc. of adrenal cortical extract is given at once intramuscularly and 10 cc.

\*Abbott Co.—A4137.

\*\*Abbott Co.—A4130.

\*\*\*Abbott Co.—Venoclyst Outfit-Tube and Needle Set A4141.



intravenously. Ten cc. of extract is administered every hour for the first six or eight hours and as often subsequently as warranted. During the first few days of crisis the daily dose of extract may approach 100 to 150 cc. In the presence of infection the dose required is larger.

A nurse is in constant attendance and is warned of the possibility of hypoglycemia, especially three to four hours after cessation of the intravenous solution. Desoxycorticosterone acetate in doses of 3 to 10 mg. may be given during the first two or three days, but the daily dose usually does not exceed 5 mg. Experience has emphasized that a crisis can not be adequately treated with desoxycorticosterone acetate alone.

Whole blood transfusions are to be avoided, since a transfusion reaction may prove fatal. When necessary, circulatory support can best be obtained by one or more transfusions of 250 to 300 cc. of freshly separated plasma.

Sulfonamides or penicillin should be employed when the presence of infection is established. The patient is encouraged to take frequent feedings with sufficient protein. If the patient's condition remains critical for more than 12 to 24 hours, frequent tube feedings are administered. When the critical stage has passed, treatment is that for the uncomplicated case.

3. Crisis in a patient with desoxycorticosterone pellets in situ. Treatment of crisis in a patient who has an implanted pellet differs in several ways from that previously outlined. A sense of security because of the implanted pellet is unwarranted. Since desoxycorticosterone causes rapid excretion of potassium, the serum potassium may fall to dangerously low levels in crisis. Therefore, at least part of the daily normal potassium intake should be maintained when the patient with pellet implants is in crisis or in danger of crisis. Ringer's solution is preferable to sodium chloride solution. Ringer's solution supplies 0.42 gm. of potassium per liter. Potassium chloride may be added in doses of about 4 gm. per day.

Administration of extra potassium may be distinctly dangerous, unless the patient is absorbing desoxycorticosterone. Accordingly we must rely principally upon adrenal cortical extract. Large doses of extract under these circumstances may be followed by slight edema, especially if saline solution has been given. Usually additional desoxycorticosterone need not be administered when a pellet is in place, unless the life of the pellet is near termination.

We believe that in general the following cardinal rules are valuable as to what not to do in the treatment of Addison's disease:

1. Do not give a transfusion unless the necessity is extreme, since a transfusion reaction may prove fatal. If transfusion is imperative, do not

give whole blood. The least dangerous type is freshly separated plasma from fasting blood.

2. Do not apply a tuberculin test. Treatment will not be influenced by the results obtained, and a strongly positive skin reaction may be followed by persistent fever.

3. Do not give insulin. Patients with Addison's disease run sufficient risk of hypoglycemia, which should not be increased. The co-existence of Addison's disease and diabetes mellitus is very rare.

4. Do not give thyroid extract unless the indications are unmistakable, and then with caution.

5. Do not treat tuberculosis of the adrenal glands with X-ray, since a crisis may follow.

6. Do not withhold potassium when desoxycorticosterone is being employed. Abnormally low serum potassium levels may be dangerous.

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# Peptic Ulcer As It Occurred At A Station Hospital: A Report of 207 Consecutive Cases

ROBERT C. KIRK, M.D.

**P**EPTIC ulcer is probably the most common severe digestive disease present today in military personnel and in civilians; certainly in the United States. Except in a few teaching institutions in the several states, the opportunity to closely follow any considerable number of patients with this disease is either not feasible or not possible. Accordingly, it would seem to be of value to summarize the experiences gained in the gastrointestinal section of one army installation over a 16-month period from October 1, 1942, to March 1, 1944.

The admission, follow-up, and disposition of each case was the personal responsibility of the writer insofar as it is possible in military hospitals. This was afforded by the closest cooperation of all the allied services. The pertinent findings have been summarized in the following chart. References to the recent available literature may be found in a previous communication.<sup>1</sup>

**Total Admissions to Service**—1306; Duodenal Ulcer, 200; Gastric Ulcer, 7; Per Cent Peptic Ulcer, 15.

**Racial Distribution of Duodenal Ulcer**—White soldiers, 151; negro soldiers, 49.

**Age Distribution**—18-45.

**Onset of Digestive Symptoms**—First Decade (1-10), 11; Second Decade (10-20), 40; Third Decade (20-30), 104; Fourth Decade (30-36) (Oldest), 45.

**Chronic Cases**—(Duration over 12 months)—173; (average duration, 5.5 years).

**Acute Cases** (Duration under 12 months)—27; (average duration, 6.5 months).

**Symptomatology** (200 cases)—

|                              | Per<br>Cent |
|------------------------------|-------------|
| Relief from milk             | 95          |
| Relief from alkali           | 91          |
| Pain at night                | 89          |
| Intolerance to "greasy food" | 87          |
| Easy fatigability            | 80          |
| "Pit" Aching                 | 79          |
| "Pit" Burning                | 79          |
| Bloating and Belching        | 77          |
| Vomiting                     | 76          |
| Pressure Feeling             | 71          |
| Gnawing                      | 70          |
| Pain in back                 | 51          |

**Physical Findings** (200 cases)—

|                                      | Per<br>Cent |
|--------------------------------------|-------------|
| Soreness in the mid-epigastrium      | 93          |
| "The lean and hungry look"           | 14          |
| Depressed facies                     | 11          |
| Weight loss—0 to 40. Average 13 lbs. |             |
| None in 25 per cent.                 |             |

## The Author

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**Laboratory Examination** (200 Cases)—

"Positive" X-ray findings—100 per cent.

White Blood Counts—Range 3,400 to 22,000. Average 8,300. Over 12,000 in only 7 cases.

Polymorphonuclear Count—Definitely elevated in 5 instances.

**Sedimentation Rate** (Normal 0-10 mm)—Range 1 mm to 23 mm/hr.—Average 6 mm.

**Red Cell Count and Haemoglobin**—Below normal values in 13.

**Gastric Analysis** (Ewald and/or alcohol meal—Fasting Free Acid 22.6°—Range 0-68°—20 cases showed achlorhydria.

Fasting Total Acid 45.1°—Range 4-113°.

Test Meal Free Acid 37.5°—Range 0-111°—11 cases showed achlorhydria.

Test Meal Total Acid 61.3°—Range 4-120°. Free Acid was obtained in all cases after ½ c.c. of histamine.

|                      | Per<br>Cent |
|----------------------|-------------|
| Gastric Occult Blood | 15          |
| Fecal Occult Blood   | 35          |

**Complications**—

5.5 per cent, or 11, soldiers were operated upon for perforated duodenal ulcer. No deaths.

5 per cent, or 10, soldiers were admitted for recent acute hemorrhage—Moderate in 3 (red count above 3,000,000)—Severe in 7 (red count below 3,000,000).

6 per cent, or 12, additional soldiers had a definite history of hemorrhage prior to induction.

11 per cent of this series have sustained acute rapid blood loss (observed and histological).

**Miscellaneous**—

1. 35 per cent of these soldiers abstained from intoxicating beverages.



2. 16 per cent of these soldiers did not use tobacco.
3. 10 per cent had appendectomies, of whom 10, or 50 per cent, were unimproved.

#### SUMMARY AND CONCLUSIONS

1. The ratio of duodenal to gastric ulcer is 28 to 1. This figure remained nearly constant during the 16-month observation period.

2. The percentage of Negro soldiers having duodenal ulcer based on the population of the camp was approximately three times that of the white soldiers. This is explained as evidence of lack of diagnostic facilities available to them prior to induction. There was no observable racial difference in the disease.

3. Not apparent from the chart was the constant admission diagnosis of peptic ulcer in men who were found to have normal gastro-intestinal X-rays in a fixed ratio of 1:1. These 200 cases had many of the symptoms given above but on closer study they fell into that vague classification, "functional" gastro-intestinal disease.

4. An elevated white blood count, sedimentation rate, or polymorphonuclear count in duodenal ulcer does not occur in the absence of severe complications.

5. Gastric analysis with the Ewald or alcohol test meal was of no diagnostic value in duodenal ulcer.

6. A duodenal ulcer has a 10 per cent chance of producing hemorrhage during its course and a 5 per cent chance of perforating.

7. Alcohol and tobacco are not implicated as etiological factors in this disease by the author's data.

8. A careful gastro-intestinal examination is recommended prior to surgery in all cases of chronic abdominal distress.

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#### Mass X-rays

As a method of tuberculosis case-finding, the screening of large groups of apparently healthy individuals by means of chest X-ray is here to stay. It should not replace the recognized routine methods of case-finding by means of examination of individuals who have been in close association with tuberculous patients or who have symptoms referable to the lungs. Rather, it should serve as an excellent auxiliary method for the discovery of new cases and in that way provide to health department many additional opportunities for the promotion of their tuberculosis control programs.—William Siegel, M.D., "Health News", Nov. 13, 1944

\* \* \*

There has been a gradual and noticeable increase in morbidity of tuberculosis in the aged.—Arthur Rest, M.D., Amer. Rev. of Tbc., March, 1942.

#### KEEPING UP WITH MEDICINE

**E**LEPHANTIASIS is a complication of filariasis that arises after many years where the assaults on the tissues had occurred and recurred constantly over many years.

\* \* \*

**T**HE modern methods of sewer purification are based upon the long known fact that soil is a destroyer of offensive wastes but it took a long time to arrive from there with penicillin crystals.

\* \* \*

**O**NE gram of soil contains millions of bacteria, fungi, actinomyces, protozoa, and other forms of life. It is upon these that we depend for our very lives. Soil is not a bag of chemicals but a nicely balanced biologic system.

\* \* \*

**I** THINK we should look upon the contents of our colon as a compost pile being digested into nice, sweet soil. We should therefore refrain from poisoning our friendly intestinal organisms with chemical poison, except in case of extreme necessity (cathartics, sulpha drugs, etc., etc.). By careful attention to diet we should strike a balance between fermentation and putrefaction.

\* \* \*

**I**F, on the other hand, you look upon the contents of your colon as sewage, its decomposition can be effected without the production of poisons or unpleasant odors. Much attention should be paid these things.

\* \* \*

**A**S a result of an undischarged emotional tension, the individual may have a set of symptoms easily mistaken for heart disease, asthma, peptic ulcer, toxic goitre, or convulsive disorders.

\* \* \*

**A**CCUMULATION of intermediary metabolites in the milk of lactating women may be encountered in acidosis, ketosis, anoxemia, uremia, and latent vitamin B<sub>1</sub> deficiency. Such milk may be poisonous to the nursing infant.

\* \* \*

**C**HILDREN who show extreme irritability, restlessness, hyperacidity, anorexia, and small stature should be studied from the viewpoint of possible hypothyroidism.

\* \* \*

**T**HE treatment of ventilatory insufficiency consists of breathing exercises, inhalation of broncho-dilator drugs, and control of bronchopulmonary infections. Even primary cardiac conditions are not contraindications for the use of ephedrine when there is ventilatory insufficiency.

—J. F.

# Fatal Hemolytic Reaction Following Transfusion With Incompatible Blood\*

A. J. MANTILLA, M.D.

**Case History:** The patient, a white male, 64 years of age, was admitted to University Hospitals for the first time on January 27, 1945. He had been well until one week before admission at which time he noticed gradual onset of generalized malaise, jaundice, vomiting and pain beneath the ribs anteriorly. He was employed in a paint factory.

Physical examination revealed a pale, well developed and well nourished white male with slight generalized icterus. The lungs were clear. The heart was normal in size and there was a soft blowing systolic murmur at the apex.

Laboratory observations were: 900,000 red blood cells per cubic millimeter, 26 per cent hemoglobin, 10,000 white blood cells per cubic millimeter with 73 per cent polymorphonuclear neutrophils, 12 per cent lymphocytes, 10 per cent monocytes, 1 per cent basophils and 4 per cent myelocytes. Sternal bone marrow puncture revealed a low total cell count, due either to a hypoplastic marrow or to simple dilution with blood during the sternal puncture. The nucleated red blood cells showed a significant increase consistent with pernicious anemia or with hemolytic anemia.

In view of the leucocytosis, the normal number of platelets and the elevated icterus index a hemolytic anemia was considered as the most likely possibility. The red blood cells did not show the marked variation in size and shape ordinarily associated with pernicious anemia. However, the erythrocytes were macrocytic as measured by the mean corpuscular volume.

In an attempt to improve his anemia, the patient was given 500 cc. of whole blood. During the transfusion he suffered a marked reaction and died 8 hours later. He had received blood from a donor belonging to group AB. A series of experiments was then performed with his serum and cells to find the cause of the reaction.

In the original typing his cells agglutinated with all typing sera (O, A and B) and he was thought to belong to group AB. The agglutination in A typing serum was not as marked as in O and B. It was also found that the patient's cells agglutinated in his own serum to about the same degree as in type A serum and there was a tendency of the cells to agglutinate even when placed in saline. These phenomena were considered characteristic of cold hemagglutination.

The cross matching was repeated and showed that the patient's serum hemolyzed the donor's AB cells without any signs of agglutination. This was true even 24 hours after the serum had been drawn. After the transfusion with the AB incompatible blood, the patient's serum agglutinated instead of hemolyzing the AB cells used in the transfusion. The patient's serum,

obtained before the transfusion, when heated to 56° C. agglutinated the donor's AB cells without any appreciable hemolysis.

In conclusion, the patient was actually of blood group A. The presence of cold hemagglutinins caused the cells to agglutinate with all typing sera so that the patient was erroneously considered to belong to group AB. The cross match failed to show this because the patient's serum did not agglutinate the donor's cells but hemolyzed them instead. When the preparation was examined after 45 minutes, the hemolysis had not progressed far enough to be recognizable. After 75 minutes there was complete hemolysis of the donor's AB cells. If the patient's serum was inactivated there was agglutination instead of hemolysis.

**Autopsy.** The bone marrow showed hyperplasia of the red cell series with increase in the nucleated erythrocytes consistent with pernicious anemia. The kidneys showed degeneration of the tubular epithelium with hemoglobin pigment casts in the renal tubules. These features are consistent with those usually found in transfusion reactions.

## COMMENT

This case is one of hemolytic reaction occurring after a transfusion with incompatible blood. The series of experiments carried out after the reaction reveal that the erroneous interpretation of the blood typing was due to the presence of cold agglutinins in the patient's serum. Frequently cold hemagglutination is suspected when untoward results are obtained in blood group determinations. In the present case the absence of agglutination and its replacement by hemolysis in the cross matching complicated the situation and contributed to the erroneous interpretation of the reaction.

According to Stats and Wassermann<sup>1</sup> the patient's red cells generally absorb the cold agglutinins from their serum, especially if the blood is kept in the refrigerator. If they are mixed at room temperature with anti-A and anti-B sera, the resulting agglutination may be interpreted as isoagglutination and the conclusion will be that the blood belongs to group AB. The serum from a patient from group AB should be free from isoagglutinins. However, the serum from a patient with potent cold hemagglutinins will agglutinate any red cells, including group O, at a low temperature and sometimes at room temperature.

To guard against errors in blood grouping it is advisable to check group AB by the performance of the grouping test at 37° C. If the cold agglutinins are of high titer it is neces-

\*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the twenty-eighth of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems".



sary to use erythrocytes washed by centrifugalization with normal saline solution. If cells are prepared in this manner and mixed with potent anti-A and anti-B sera at 37° C. the blood grouping will be dependable. If unwashed erythrocytes are to be used for grouping, the test must be performed at 37° C., for at this temperature cold hemagglutinins are not active. In the performance of the cross match using the donor's erythrocytes and the patient's serum, cold hemagglutination can be prevented only by carrying out the reaction at 37° C.

In regard to hemolytic transfusion reactions, Kilduffe and DeBakey,<sup>2</sup> in a collected series of over 40,000 transfusions found 80 hemolytic shock reactions (0.18 per cent), of which 32 were fatal (0.07 per cent). In these the reaction usually occurred, as in the present case, during the transfusion or immediately following its completion. Occasionally the reaction was delayed and the initial manifestations developed from one to several hours afterwards.

In the typical cases the patients complained of a sense of great discomfort and anxiety, precordial oppression and difficulty in respiration. There was generally pain in the back, especially in the lumbar region. Signs of collapse usually accompanied this picture with rapid feeble pulse and fall in the blood pressure. Following this episode, there was generally some improvement and later the onset of hemoglobinuria, followed by oliguria and finally anuria with coma. Death usually occurred within a week after the reaction.

The outstanding feature in these types of reaction is the renal insufficiency. Grossly the kidneys are swollen and microscopically there is marked diffuse nephrosis and the deposition of hemoglobin pigment casts in the renal tubules. Many attempts have been made to explain the pathogenesis of the renal lesions and the anuria. At present there is no satisfactory explanation. In dogs, De Gowin<sup>3</sup> and his coworkers emphasize the mechanical blockage of the renal tubules caused by the precipitation of hemoglobin in contact with acid urine. These authors advised the alkalization of the urine to prevent the renal insufficiency. DeNavaquez has presented clinical and experimental observations to refute the theory of mechanical blockage. In three transfusion reactions, the urine was kept alkaline without prevention of anuria and death. Histological examination of the kidneys showed no evidence of tubular obstruction. Large doses of hemoglobin in solution were repeatedly injected into rabbits with both acid and alkaline urine and there was found a higher excretion rate in the acid and a greater retention of iron containing pigment in the alkaline.

That the kidneys become sensitive to a substance present in the incompatible blood has

also been considered as a possible explanation, based upon certain clinical observations in which renal insufficiency occurred coincidentally with the appearance of urticaria. A hemolytic reaction could occur in a patient hypersensitive to substances present or liberated by the incompatible blood. However, experimentally, the syndrome can be produced by a single transfusion.

Mason and Mann<sup>4</sup> observed a transient diminution in the urine volume of dogs with transfusion reaction. Similarly Hesse<sup>5</sup> has found a decrease in urine volume as well as diminution in blood pressure following the intravenous injection in dogs of both hemolyzed, homogeneous and heterogeneous bloods. Accordingly, they believe that the primary mechanism is a constricting action of the hemoglobin on the renal vessels with ischemia. They have produced relaxation of this spasm and have restored the function of the kidneys by transfusion with compatible blood.

From the discussion of the various theories, it is evident that many phases of this subject are still obscure. Recently, similar renal lesions have been described in the so-called "crush syndrome" and are known to occur in relation to paroxysmal hemoglobinuria, black water fever, burns, poisoning by potassium chloride and toxemia of pregnancy, especially eclampsia.

The severity of the reaction is directly proportional to the amount of blood administered. Daniels<sup>6</sup> in a report of 13 cases finds a mortality of 70 per cent in patients receiving 500 cc. or more of blood and no mortality in patients receiving 350 cc. or less. In the present instance the patient received 500 cc. It is thus advisable to stop immediately a transfusion in the course of which a reaction is suspected.

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We must always remember that good health is itself one of the best preventives of tuberculosis.—Fred H. Heise, M.D., *NTA Bull.*, Jan., 1945.

One active case of tuberculosis in a group of silicotic workmen can create a situation of potential dynamite.—L. E. Hamlin, M.D., *Rocky Mountain Med. Jour.*, June, 1944.

# Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

## THE TUBERCULOSIS DEATH RATE IN WARTIME

Inasmuch as war conditions usually lead to an increase in the incidence of tuberculosis a rise in the death rate was to be expected in 1943, the second full year of American participation in the war. For this reason the decline registered is even more encouraging than those recorded in previous years. In view of the chronic nature of the disease, however, several years may elapse before the impact of war conditions is reflected in a mortality rise. Therefore, we must all realize that the probability of an increase in the incidence of tuberculosis is enhanced each day the war continues.

The decline in tuberculosis mortality has continued steadily each year since 1936 and, with the exception of two minor interruptions, each year since 1918. These sustained decreases must be attributed to quite a number of factors, among which are:

1. Greatly improved and enlarged facilities for the care of the tuberculous, including better managed sanatoria and thousands of additional beds; a higher standard of clinic service and of public health nursing service, as well as a great improvement in health administration generally.

2. Earlier diagnosis and improved methods of diagnosis, including mass X-ray surveys among apparently healthy adults.

3. Recognition on the part of patients and their families of the importance of sanatorium care with the result that a much larger proportion of infectious patients have been segregated, thus minimizing the spread of the disease.

4. Increasing awareness of the tuberculosis problem and acceptance of the greatly amplified program of health education.

5. Decided improvement in the standard of living throughout the country.

6. Intensive efforts directed toward certain groups, such as high school and college students, medical students, nurses, expectant mothers and young women generally. More recently these efforts have been directed toward industrial employees, Negroes and Spanish-speaking people, and men and women who are being examined for service in the armed forces.

The most interesting trend noted in 1943 is the fact that so many of these increased death rates are concentrated in the industrial states of the northeastern and north central sections of the country, while, on the other hand, even more pronounced declines are noted in the states of the south and west.

According to one theory, these increased rates in our industrial states may indicate rising mor-

tality from tuberculosis in the country as a whole. Others are of the opinion that the stupendous migration of the past few years may have resulted in a realignment of the American people—to some extent, at least, on health grounds. Only time can determine which of these two hypotheses is correct.

The abnormal conditions incident to the war have affected the population distribution in the states more than is usually realized. Internal migration, both civilian and military, has resulted in decreased population in the north-eastern and north central states, while in the south and west the population has increased materially since the date of the last decennial census in 1940.

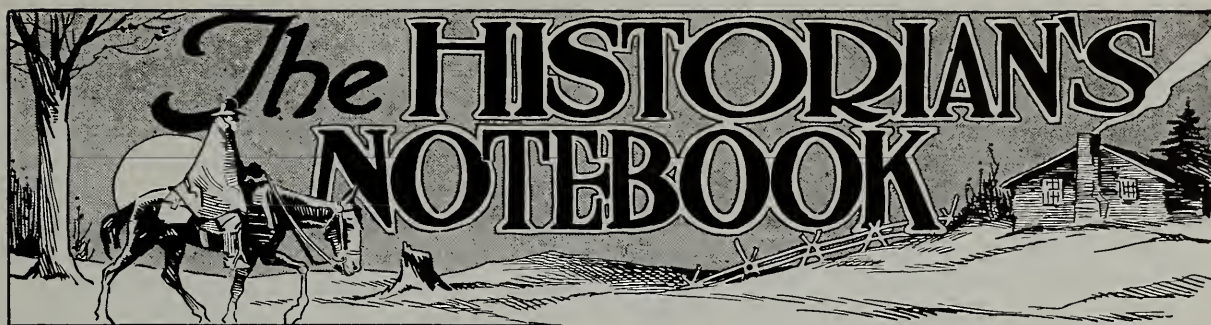
The assignment of millions of the country's healthiest young men and young women outside continental United States and the elimination of their number from population estimates upon which death rates are based, have had their effect of raising tuberculosis mortality slightly in the country as a whole. Many more millions of our healthiest young citizens have likewise been assigned to training camps which are largely concentrated in the states of the south and far west, where climatic conditions facilitate military training throughout all months of the year.

Since all (or approximately all) of these young people had been recently X-rayed it is highly probable that the deaths from tuberculosis among their number would have been negligible in 1943; yet 2,500,000 of them were eliminated from the population base on which the death rate is computed.

Simultaneously other millions of all ages whose state of health is unknown have migrated to and fro without pattern in search of industrial employment. It is quite possible that this population upheaval, which has no parallel in American history, will affect the trend of tuberculosis mortality in the states for years to come.

Changes in the size of a state's population are allowed for when death rates are computed on the basis of the best available population estimates. But changes in the age, sex and color composition of the population cannot be taken into consideration until a new population census has been taken. Obviously, no population census will prove to be worth while until the people of the country have had a few years to settle down after the war.—What is Happening to the Tuberculosis Death Rate? Mary Dempsey, *American Review of Tuberculosis*, December, 1944.





*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## Medical Curiosities—Phosphorus

RALPH M. WATKINS, M.D.,

AT hand is another interesting and curious old pamphlet, published in 1878 by William R. Warner & Co. of Philadelphia. The title, "Phosphorus in Functional Disorders of the Nervous System Induced by Overwork and Other Influences Incidental to Modern Life". It is compiled from "various sources including E. A. Kirby, M.D., and Prof. J. A. Thompson", both Britons. The pamphlet has a cover which contains the one word "Phosphorus" and is unusual for those times because that word is in color, a shade of brown which may be buff, and from the horns of the large letters run great streaks of this color, irregularly angular, surely representing lightning, and all of this on a background of clouds ranging from light gray to black and surrounded by a decorated border. In other words, Phosphorus is being presented to the reader as a bolt from heaven.

This pamphlet is rather long, 49 pages, but I should like, as heretofore, to quote directly from it at intervals. In these old publications, grandeur and pomposity of expression are used in a way we do not often meet in modern days.

Obviously, the Warner Co. is trying to convince the profession that their new (1870) Phosphorus pills should have wide usage, together with their many other phosphorus compounds. To do this, they deem it necessary to acquaint the physician with the properties and uses of phosphorus and naturally stimulate sale of their products. Much is made of the accuracy of dosage and elegance of their preparations as compared with the crudities of older ones made, I presume, by competitors.

After this introduction, the pamphlet next deals with a description of the Phosphorus, what it is and what it does. A table gives the chemical structure of nervous matter—the water, al-

### *The Author*

● Dr. Watkins, Cleveland, Ohio, is a graduate of Syracuse University College of Medicine, 1920; F.A.C.P.; diplomate; American Board of Internal Medicine; and chief of Medical Service, The Woman's Hospital, Cleveland.

bumen, fat, osmazome and salts, and phosphorus content thereof in infants, youths, adults, the aged and, for good measure, idiots. In case you do not know osmazome (I did not), Webster, edition 1882, defines it: "A substance obtained from muscular fiber, which gives the characteristic odor and taste of soup, and was formerly supposed to be a definite compound". Of interest is the fact that idiots have only about half as much phosphorus in nervous tissue as adults, and have about the same amount as infants. The composition of nerve substance proper is further broken down into protargon, neurine, fatty matters combined with phosphorus, and bases combined with peculiar fatty acids. "Protargon  $C_{116}H_{241}O_{22}N_4P$  was described by Liebreich in 1865 . . . three classes of phosphorized bodies have been discovered in the brain, viz., kephalius, myelius, and lecithius . . ."

"Excessive activity of the nervous system increases the waste of Phosphorus; and whenever the elimination is increased, nervous force is always reduced. . . . In inflammatory diseases of the brain . . . a marked increase of the alkaline phosphates in the urine" is present. This is true in excessive mental work, too. For example, according to a Dr. Carpenter, "among clergymen, in the preparation for and discharge of their Sunday duties".

Much emphasis is placed on the results of spermatorrhea. "The spermatic fluid is rich in Phosphorus, and its emission from the system, in whatever manner produced, is, when excessive, highly injurious. The nervous centers being deprived of their proper pabulum . . ." develop frightening things, "cerebral and spinal paresis, neuralgia, epilepsy, melancholia" which may lead to death, all due to "seminal waste". Minor symptoms are "premature failure of mental power, loss of memory, irritability, nervousness and extreme depression". Quoting a Mr. Acton, "Many of the most . . . obscure diseases which the medical man meets with, arise from repeated 'loss' even excesses too often committed by married persons in ignorance of ill effects". "Of all vices, none are more apt to lead to consumption . . ." according to Dr. Cotton. Dr. Smith found that over half his tuberculosis patients were victims of sexual excess.

So far it has been shown that Phosphorus is indicated in conditions the result of "Early indiscretions, vicious and irregular habits, intemperance, worry and overwork, failure in business or reverse of fortune, mental strain, prolonged anxiety, excessive grief, etc."

Other uses: "Chorea, . . . neuralgia . . . diarrhea of phthisis, pneumonia, malignant jaundice, fatty heart, atheroma of the arteries, molities ossium, softening of the brain and spinal cord, nephritis, muscular weakness in children, incipient caries, purpura, functional paralysis, adynamic fevers, hectic fever, progressive spinal paralysis, marasmus, general debility, chronic catarrh, arthritic hemicrania", etc. Phosphorus is "nutritive, tonic, stimulative".

At this point comes a section on pharmaceutical preparations. Phosphites and hypophosphites are discussed and pronounced uncertain in action. Phosphide of Zinc is nauseating. Red Amorphous Phosphorus contains no free Phosphorus. Oleum Phosphoratum B.P. is "indigestible". Phosphorus "Perles" dissolved in the stomach, cause eructations of phosphorated hydrogen. Finally, Phosphorus in pill form is best, but previous preparations have been unreliable. Only now has the Warner Co. perfected it.

Next is a section devoted to Phosphorus in Functional Disorders. This is divided into several sub-sections and how familiar sounds the first: Overwork and Fast Living! Here are several quotations from Mr. W. R. Greg's lecture "Life at High Pressure. . . The rapidity of railway travelling produces a chronic disturbance of the nervous system. . . Anxiety to be on time . . . hurrying pace . . . heart disease, too common already, may be expected to be more common still". (How true we know that to be.) "The eminent lawyer, the physician in full practice, the minister . . . even the literary work-

man and eager man of science . . . break down . . . shattered, paralyzed, premature senility . . . much to retire upon, nothing to retire to." Associated factors often present: "Defective hygiene . . . damp situations . . . confined neighborhoods . . . scanty supply of fresh air and sunlight . . . bad drainage."

How does one know he is overworking? By "fatigue not removed by repose . . . errors in work . . . forgetfulness . . . wakefulness . . . a sinking, empty feeling in the chest . . . mind spiritless and depressed with gloomy forebodings of evil . . . taciturnity . . . irritability . . . irregular heart . . . rapid pulse . . . nutrition arrested, the muscles waste, color fades", then "paresis".

The next subject: Impotence, natural result of excesses (see above). Treatment: Phosphorus, Nux Vomica, Strychnia, Faradisation.

Then Nervous Indigestion, from "loss of nerve power". Treatment: Remove cause, less work, more exercise, less hurry, diet, Phosphorus or Phosphorus with Nux Vomica with or without Aloes.

Then Gout, the attacks brought on by "grief, fear, . . . anger . . . venereal excesses . . . Phosphorus acts as a solvent for uric acid".

Now Melancholia or Emotional Insanity. This is caused by "over brain action . . . produces . . . loss of nerve power". Treatment: Phosphorus (3 cases cited).

Next is Neuralgia. This is due to "the nervous system not duly nourished". Phosphorus is definitely to be used in "Facial neuralgia and brow ache" and in sciatica. Also one should try to determine the cause. There are reported 15 cases of trigeminal neuralgia, 14 cured by Phosphorus. (This is better than our neurosurgeons can do these days. I suspect that 15 patients did not have true tic doreux.) Women suffer greatly from neuralgia; this is due to "hyperfecundation, rapid child-bearing, frequent miscarriages, hemorrhage, prolonged lactation. . . ." Best treatment is "opium and aconite". Use "hypodermic injection, the sixth of a grain of Sulphate of Morphia". (We wonder how many drug addicts resulted from this therapy.)

Then comes Temporary Nervous Exhaustion and a Dr. Janney reports the case of his nephew who suffered thus and was cured by "Warner and Company's Compound Phosphorus Pills".

"Nervous Prostration occurs in the later stages of typhus and typhoid fevers, pneumonia, and other asthenic conditions" and Phosphorus must be given "boldly".

In Hysteria, "a direct expression of exhausted vital power . . . Phosphorus may usually be employed with much advantage. . . The moral treatment is . . . of great importance".



Epilepsy and "Epileptic Vertigo" are due to "over mental exertion, venereal excesses, menstrual derangement, anxiety and grief, indigestion, dentition, . . . frights, blows, sunstrokes, fever, etc.," and Phosphorus with Zinc should be used for six or eight months at least.

In Cerebral Softening, Phosphorus treatment gives better results if the disease is gradual in onset and not sudden, the result of thrombus, embolism or hemorrhage.

Many Skin Diseases arise "from defective nutrition" and "Phosphorus is . . . useful . . . in psoriasis, chronic eczema, pruritus . . ."

Near the end of the Pamphlet is a section entitled: Directions for Regimen, Diet, etc., in the treatment of Functional Disorders of the Nervous System. It is summarized and recommends:

1. Complete rest of mind.
2. Encouragement of a new hobby or study.
3. Tranquillity of the senses.
4. A nourishing diet, especially rich in fish.
5. The internal administration of Phosphorus

prepared by Wm. R. Warner and Co.

Further, this program is supported by Prof. Delpech, Prof. Fisher of Berlin, Dr. Eames of Ireland, Dr. Burgess and Dr. Hammond of New York.

Finally comes a list of some 20 combinations made by the Warner Co. in which Phosphorus is present. It might be of interest to note that, in varying proportions, it is joined with Nux Vomica, Iron, Quinine, Digitalis, Cannabis Indica, Morphine, Zinc, Opium, Strychnine and Cantharides.

\* \* \* \* \*

Phosphorus has assumed its rightful place in our medical economy. One wonders how many of our current highly popular medical preparations will have maintained their elevated position sixty years hence; probably very few.

### Control of Rabies in Dogs

Rabies in dogs can be controlled by quarantine and by immunization against the disease through a single injection of the vaccine, *The Journal of the American Medical Association* for April 28 reports. *The Journal* says that experiments now have established that the single injection of an antirabic vaccine produces a high degree of immunity in the dog.

"An effective program to control canine rabies", *The Journal* states, "must include quarantine to prevent the spread of the virus by stray dogs and dog traffic. There seems to be no question that canine rabies can be controlled by means of quarantine and vaccination. . . ."

### Licensed Through Endorsement

The State Medical Board has granted licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states: January 9, 1945—David I. Abramson, Cincinnati, Long Island College; Richard H. Beiswanger, Toledo, Univ. of Minnesota; John R. Braunstein, Cincinnati, Univ. of Cincinnati; Arthur C. Corcoran, Cleveland, McGill Univ.; Donna C. Cowgill-Crosley, Cleveland, Univ. of Nebraska; William F. Gerber, Middletown, Univ. of Arkansas; George W. Gibbins, Cleveland, Univ. of Arkansas; Edward J. Humphreys, Columbus, College of P & S, Columbia; Seibels R. Green, Jr., Lima, Meharry Medical College; David B. King, Springfield, Indiana Univ.; Nelson E. Klamm, Cleveland, St. Louis Univ.; William L. Lacy, Dayton, Univ. of Virginia; Nathan S. Hale, Wilmington, St. Louis Univ.; Howard E. Smith, Toledo, Univ. of Virginia; Wilfred T. Tumbusch, Dayton, St. Louis Univ.; John S. Wisely, Cleveland, McGill University.

April 3, 1945—Leon H. Caviness, Worthington, College of Medical Evangelists; Lemuel W. Diggs, Cleveland, Johns Hopkins; Oliver Eitzen, Lakewood, Kansas Univ.; Robert A. Fanning, Dayton, Univ. of Louisville; E. Kenneth Harris, Cleveland, Univ. of Colorado; Howard W. Heywood, Dayton, Northwestern Univ.; Alexander M. W. Hursh, Cleveland, Jefferson; Robert M. Kiskaddon, Cleveland, Cornell Univ.; Else Klein, Cincinnati, Syracuse Univ.; Edward S. Koziowski, Cleveland, St. Louis Univ.; Attilio Laguardia, Columbus, College of P & S, Columbia; Middleton H. Lambright, Jr., Cleveland, Meharry Medical College; Gordon B. Munson, Middletown, Univ. of Illinois; Irvine H. Page, Cleveland, Cornell Univ.; Frank F. A. Rawling, Toledo, Univ. of Western Ontario; Esther E. Reed, Mansfield, Wayne Univ.; Werner F. Schmiesing, Lima, Marquette Univ.; Garner Scullard, Warren, Univ. of Toronto; Edward D. Sprott, Jr., Bellefontaine, Meharry Medical College; James B. Stewart, Cleveland, Rush Medical School; John J. Toma, Dayton, Univ. of Budapest; Arthur H. Ulmer, Jr., Toledo, Univ. of Michigan; Willard A. Van Nest, Toledo, Loyola Univ.; Raymond A. Weitemier, Greenville, Univ. of Michigan; Esther R. Wilks, Dayton, Univ. of Michigan; Robert E. Wirtz, Canton, St. Louis University.

According to *Health News*, Dr. Marion F. Loew, assistant director of the division of maternity, infancy and child hygiene of the New York State Department of Health since 1936, left that service Feb. 23 to join the Samuel S. Fels Research Institute, Antioch College, Yellow Springs.

## Annual Conference on Conservation, Nutrition and Human Health To Be at Athens, June 30-July 1

The Fourth Annual Conference on Conservation, Nutrition and Human Health, sponsored by the Friends of the Land and Ohio University, will be held at Athens, Saturday and Sunday, June 30 and July 1. The program follows:

### Saturday, June 30—Afternoon Session

Ollie E. Fink, executive secretary, Friends of the Land, presiding.

- 1:30 P.M. "Introduction and Welcome", President John Baker, Ohio University.
- 2:00 P.M. "Southeastern Ohio Adjusts Her Land Use", John Sitterly, Ph.D., associate professor of rural economics and sociology, Ohio State University, Columbus.
- 3:00 P.M. "The Church in Rural Reconstruction", Rev. Henry Retzek, St. Alexis Church, West Union, Minn.
- 4:00 P.M. "Protecting a Watershed", Bryce Browning, secretary, Muskingum Conservancy District, New Philadelphia.

### Recess

### Evening Session

Chester Davis, President, Friends of the Land, and the Federal Reserve Bank, St. Louis, presiding.

- 7:30 P.M. "Soil Erosion and Civilization", Walter O. Lowdermilk, assistant chief, U.S. Soil Conservation Service, Washington, D.C.
- 8:30 P.M. "Saving This Land of Ours", Louis Bromfield, D. Litt., writer and farmer, Lucas.

### Sunday, July 1—Morning Session

Jonathan Forman, M.D., Columbus, Editor, The Ohio State Medical Journal, presiding.

- 9:00 A.M. "Changing the Food Habits of Our People", Martha Koehne, Ph.D., Ohio Department of Health, Columbus.
- 10:00 A.M. "The Adequacy of Our National Food Supply", William E. Krauss, Ph.D., chief of the Dairy Department, Ohio Agricultural Experiment Station, Wooster; member of subcommittee on food supply, National Research Council.
- 11:00 A.M. "Soil in Relation to Health", C. R. Orton, Ph.D., Dean, College of Agriculture and Director, Agricultural Extension Service, West Virginia University, Morgantown, W. V.

### Recess

### Afternoon Session

Mr. Fink presiding.

- 2:00 P.M. "Nutrition and the Prevention of Disease", Philip Norman, M.D., and James Rorty, New York City.
- 3:00 P.M. "Ohio University and Conservation," C. L. Dow, Ph.D., Department of Geology, Ohio University.
- 3:30 P.M. "Current Thinking in Conservation and Nutrition", (an attempt to summarize what has been learned during the conference) Dr. Forman.

All interested Ohio physicians are cordially invited to attend the conference. Because of the food situation, it is necessary that those who plan to attend send their reservations to Ollie E. Fink, executive secretary, Friends of the Land, 1 South Fourth St., Columbus 15, who also will be glad to furnish additional details about the conference.

## Studies of Hospital Facilities Being Made in Many States

The need for comprehensive studies of hospital facilities has become widely recognized among the states and hospital survey committees are in one stage of organization or another in 32 states, according to Dr. A. C. Bachmeyer, director of study of the Commission on Hospital Care, which is advising with the state groups.

A survey of health service (exclusive of the City of Baltimore) has been published in Maryland. Hospital survey committees working under official state planning commissions have been established in Alabama, Nebraska, New Jersey and Oklahoma. Special governors' commissions to study hospital or health service have been appointed in Iowa, Massachusetts, Michigan, Missouri, New York, North Carolina, North Dakota, Utah and Virginia. The state health departments are making hospital studies in Georgia and Wisconsin.

Indiana has passed legislation providing for the state board of health to make a survey of all hospital and health center facilities in the state. Legislation designed to establish study groups is pending in California, Connecticut, Maine, Oregon, Rhode Island and Washington. State hospital associations have appointed special committees to work toward the establishment of official study groups in Florida, Illinois, Kansas, Minnesota, Montana, Ohio, Texas and West Virginia.

The results of the state studies will be assembled and correlated by the Commission on Hospital Care, which was organized at the suggestion of the American Hospital Association to make a national survey of hospital facilities and needs to serve as the basis for a unified postwar hospital plan.



# Medical Indemnity Company Incorporated by Officials of Ohio State Medical Association; Stock Will Be Sold to Physicians; Details on Project Outlined

## **Company Sponsored by Ohio State Medical Association**

under the Corporation Laws and

Insurance Laws of Ohio. Under the sponsorship of the Ohio State Medical Association, a stock medical indemnity company, Ohio Medical Indemnity, Inc., has been incorporated

## **To Provide Indemnity Against Medical and Surgical Expenses**

The purposes of the company are as follows: "To provide indemnity against medical and surgical expenses occasioned by sickness, accident or other disability, under contracts or certificates which are fair and reasonable to subscribers and which are based upon adequate but reasonable premiums, and to do all things necessary, convenient or incident thereto."

## **Incorporators: Members of Council and Committee of State Association**

Incorporators of the company are members of The Council and members of the Committee on Medical Service Plans of the Ohio State Medical Association, namely: Doctors L. Howard Schriver, Cincinnati; E. P. McNamee, Cleveland; C. C. Sherburne, Columbus; Harry E. LeFever, Columbus; E. O. Swartz, Cincinnati; H. C. Messenger, Xenia; Guy E. Noble, St. Marys; A. A. Brindley, Toledo; Fred W. Dixon, Cleveland; R. L. Rutledge, Alliance; Carl A. Lincke, Carrollton; George F. Swan, Cambridge; Gilbert R. Micklethwaite, Portsmouth; George T. Harding, Columbus; Ross M. Knoble, Sandusky; Robert C. Rothenberg, Cincinnati; Wm. M. Skipp, Youngstown; Jonathan Forman, Columbus; R. K. Finley, Dayton; Robert E. S. Young, Columbus; Carll S. Mundy, Toledo; Reyburn McClellan, Xenia; Azel Ames, Jr., Hamilton; Farrell T. Gallagher, Lakewood.

## **Capital Assets To Be Raised Through Sale of Stock to Physicians**

Before the company can receive a certificate of authority to transact business from the Superintendent of Insurance of Ohio, it must have capital assets of at least \$100,000. The capital assets (\$100,000) will be raised through the sale of 2,000 shares of preferred stock, the par value of each share being \$50.00. These shares are being offered to members of the medical profession. Subscriptions for this stock may be sent to the Headquarters Office of the Ohio State Medical Association, 1005 Hartman Theater Building, Columbus 15, Ohio. A physician may subscribe for multiple shares of stock if he cares to do so.

## **Dividend of 5% To Be Paid for Limited Period to Preferred Stockholders**

Cumulative dividends at the rate of five per cent (5%) per annum will be paid on the preferred shares out of the surplus earnings of the corporation. However, provision is made in the Articles of Incorporation for the establishment of a sinking fund from the net earnings of the corporation to be used for the redemption of the preferred stock at \$50.00 per share. This means that in due time all preferred shares will be redeemed, thus eliminating dividend payments.

## **Common Stock To Be Held by Ohio State Medical Association**

Ohio Medical Indemnity, Inc., will issue 5,000 shares of common stock with a par value of \$1.00 per share. These shares will be purchased by the Ohio State Medical Association at \$7.00 per share, thus giving the company at the beginning an additional \$5,000 in capital assets and \$30,000 in surplus. The company is specifically prohibited in the Articles of Incorporation from paying any cash dividend on the common shares. Moreover, the Articles provide that no part

of the net earnings of the corporation can ever inure to the benefit of any common shareholder.

**Management of Company Under Direction of the Medical Profession of Ohio**

Control of the policies and administrative procedures of the company is vested in the holders of the preferred

and common stock, each stockholder having one vote for each share of stock he possesses. Since the greater portion of the stock will be held by individual physicians and the Ohio State Medical Association, the control of the company will be in the hands of the medical profession.

**Thirteen Members of Board of 21 Will Be Physicians**

General charge, supervision, control and direction of the business of Ohio Medical Indemnity, Inc., will be handled by the Board of Directors, elected

by the stockholders. The Board of Directors will consist of 21 persons, 13 of whom must be members of the Ohio State Medical Association and 8 of whom will be elected from shareholders other than members of the Ohio State Medical Association. The officers and executive committee will be elected by the Board of Directors.

**Benefits To Be Paid to Subscribers Will Be in the Form of Cash**

Benefits which will be paid by the company under contracts to be sold to subscribers will be in the form of cash for specified services

enumerated in the schedule of benefits set forth in the contract.

**Schedule of Benefits for Specific Procedures Will Be Provided**

The schedule of benefits at the beginning will be limited to cash payments for the following services: surgery, fractures, dislocations and

obstetrics in the hospital; fractures, tonsillectomies and adenoidectomies in the doctor's office; obstetrics in the home. It is intended that the coverage will be extended to medical procedures in the hospital and additional specified office services when the legal reserves of the company are sufficient to make expansion of benefits a safe undertaking.

Indemnity benefits will range from a maximum of \$150.00 to a minimum of \$5.00, depending on the extent and seriousness of the services performed.

**Benefits Will Not Be Doctor's Fee But Will Be Cash Indemnities**

The schedule of benefits will not fix the value of the physician's services and the relationship between the physician and patient

(the subscriber) will not in any way be changed, as the physician will continue to bill the patient for the services rendered. Payment under the benefit schedule will be an indemnity toward the total cost of the service rendered. However, in establishing the benefit schedule the company has endeavored to set up amounts sufficient to meet the average usual charges for services rendered the average wage earner of moderate means.

**Schedules and Experiences of Other Similar Programs Carefully Studied**

Prior to establishing benefits and premiums, the company secured the advice of competent insurance actuaries and reviewed the experi-

ences of many other medical indemnity companies. As a result, the benefits and premiums decided upon are based on sound actuarial principles and costs of operation.

**Close Working Agreement With Blue Cross Hospital Plans To Be Set Up**

Activities of Ohio Medical Indemnity, Inc., will be carried on in connection with the activities of most, if not all, of the Hos-

pital Service Associations (Blue Cross Plans) of Ohio.

**Certain Administrative and Clerical Work To Be Handled by Blue Cross**

The Board of Directors of the indemnity company will determine the policies of the company and will manage and supervise

its activities. Under specific agreements with the company, the Blue Cross Plans



## Comments from President Schriver on Purposes of Ohio Medical Indemnity, Inc., and Need for Action Now

**I**N an official statement regarding the organization of Ohio Medical Indemnity, Inc., Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, urged members of the Association to give their active support and financial backing to this program: Said Dr Schriver:

"Your Ohio State Medical Association is asking its members to make a financial investment in an undertaking of vital importance to the people, as well as the medical profession, of Ohio.

"Your Association is taking a bold step in launching this project. It is an endeavor to do something tangible to meet the demands of the public for prepayment coverage for the costs of medical services. This is an effort to meet a real need through voluntary, democratic methods—a program under the direction of the medical profession.

"The Council of your Association is convinced that further delay on the part of the medical profession in offering this service to the public will be fatal. If we do not do the job, government or other groups will take over.

"We are asking the doctors of Ohio to invest in and have a voice in the management of the company. It is an opportunity for them to join in a common cause and in leading the way in a sound effort to meet a public demand and a public need."

will supervise enrollment of subscribers, collections and disbursements, and handle such other general administrative details as may be delegated to them by the Board of Directors of the indemnity company.

### **Subscribers to Indemnity Policy To Be Enrolled in Groups**

Subscribers will be enrolled in groups and in accordance with the enrollment policies of the Blue Cross Plans. Contracts will be available

only to members of Blue Cross Plans, except in instances where there is mutual agreement on the part of the indemnity company and Blue Cross officials.

Blue Cross Plans participating in this arrangement will be reimbursed by Ohio Medical Indemnity, Inc., for expenses in carrying on enrollment and administrative activities.

### **Moderate Operating Costs Expected Through Working Arrangements**

Through this working arrangement with the Blue Cross Plans, Ohio Medical Indemnity, Inc., will be able to keep its administrative

costs and overhead at a low figure. This will enable the company to maintain a sound financial structure at all times and provide a liberal benefit schedule—to increase benefits as earned surplus accumulates.

Moreover, through arrangements for the sale of the medical indemnity contract in connection with Blue Cross hospitalization contracts, Ohio Medical Indemnity, Inc., will have available immediately a potential market of approximately 2,000,000 Ohioans—those who are members at present of the prepayment hospital service programs operating in the state.

### **Competent Advisors Consulted in Drafting of the Entire Program**

The Council and the Committee on Medical Service Plans of the Ohio State Medical Association have given hours and hours of careful

thought and study to this undertaking. Conferences extending over a period of many months have been held. Competent insurance and legal counsel have been consulted on all phases. Representatives of the Blue Cross Plans have attended many of the conferences, offering advice and recommendations. Experiences in other states have been evaluated. Benefit schedules, premiums and administrative details of medical indemnity programs in operation in various parts of the country have been

reviewed. This project backed by the Ohio State Medical Association consists of the good features of a large number of similar undertakings. Also, it follows the policies and standards established by the American Medical Association.

### **Physicians Asked to Buy 2,000 Shares at \$50 Per Share**

Before it can start business, Ohio Medical Indemnity, Inc., must have the amount of capital required by the Ohio Insurance Laws, namely, \$100,000. The members of the medical profession of Ohio are being asked to furnish this capital by purchasing the 2,000 shares of preferred stock. They are not being asked to make a donation as the stock purchased will pay interest in the form of dividends until it is redeemed by the company. The Council of the Ohio State Medical Association has had enough faith in the success of this undertaking to appropriate a part of the reserve funds of the Association for the purchase of the common stock.

It is the hope of the incorporators that all of the 2,000 shares of preferred stock will be sold promptly, so final negotiations can be started with the Superintendent of Insurance and authorization to start business can be obtained at an early date.

### **Special Communication Being Sent to Members of State Association**

A communication requesting financial support for this undertaking is being sent to all members of the Ohio State Medical Association by President Schriver. Subscriptions will be filled in the order in which they are received. However, believing wide distribution of the 2,000 shares of stock at \$50.00 per share would be highly desirable in order to give as many individual physicians as possible a voice in the management of the company, the incorporators have reserved the right to limit the number of shares which may be purchased by any one physician if circumstances warrant.

### **Research Wins Over Dogs**

The Baltimore city council recently killed a proposed ordinance which would have prohibited the use of live dogs for experimental purposes in medical schools and laboratories of that city. Commenting on the council's action, *The Journal of the American Medical Association* for May 19 says:

"Baltimore is to be congratulated on this victory for reason and science over the sinister forces arrayed against medical research and the progress of medical science. The tragedy is that the fight in Baltimore will have to be made again and again before state legislatures, city councils and the Congress. Ignorance, fanaticism, false sentimentalism and cynical irresponsibility are diseases for which science has thus far failed to find a remedy, even with the use of experimentation on animals that has yielded so much good to both animals and man."

A proposal that Congress investigate charges that Sister Elizabeth Kenny's infantile paralysis treatment has been subjected to organized opposition, was sidetracked—at least temporarily—when the House Rules Committee took no action on a resolution introduced by Representative O'Toole, Democrat, of New York.

### **Tuberculosis "Remedy" Rumor Spiked**

Many letters have been addressed to the American Medical Association by people who think that a remedy has been found for tuberculosis. "Unfortunately", *The Journal of the American Medical Association* for May 5 points out editorially, "the columnist, Ed Sullivan, in his syndicated column not long ago, made this statement: 'To tuberculosis patients: Contact American Medical Journal on Dr. Asheshov's Western Ontario U. experiments.'"

The article that occasioned this notice appeared in *Science* for Feb. 2, 1945, by Igor Asheshov and Frieda Strelitz. "In this article", *The Journal* explains, "the authors report experiments performed at the University of Western Ontario, London, Canada, with a fungus known as *Aspergillus fumigatus*." Crude preparations with substances derived from the growth of this fungus indicate, according to the authors, that: (1) they possess a high degree of activity against staphylococci bacteria; (2) their power to arrest the growth of a certain strain of tuberculosis bacteria is higher than their action against staphylococci.

"Certainly", *The Journal* says, "this work is hardly sufficiently advanced even to suggest that any of these substances are effective in the treatment of tuberculosis. . . ."



# Policy on Reassignment of Army Doctors in War Zones Is Announced; A.M.A. Adds Protest to Use of Medical Officers Against Their Will in Veterans Administration Hospitals

MAJOR GENERAL NORMAN T. KIRK, Surgeon General of the U.S. Army, in a message appearing in the May 19 issue of *The Journal of the American Medical Association*, says that it will be the policy of the Army Medical Department to bring back to the United States medical officers relieved from service in the theaters of operations and to assign them on their return, as long as needed, to service in their specialties in American hospitals and other installations. These men will replace physicians with similar qualifications who have not had an opportunity for foreign service.

"This information", *The Journal* says editorially, "will answer the questions of many medical officers, some of whom have written and telegraphed to the headquarters of the American Medical Association asking for a definite statement on this subject." Continuing, *The Journal's* editorial says:

"Many physicians have also written to the American Medical Association protesting against the possibility that they may be assigned on their release from service with the armed forces to the Veterans Administration. These letters were brought before the Committee on Postwar Medical Service at its meeting in Chicago, May 12. That committee took prompt action, adopting the following statement, which was sent to the Secretary of War, Secretary of the Navy, and the Committees on Military Affairs of the House of Representatives and the Senate:

## TRANSFERS PROTESTED

"In November, 1944, the Army Medical Department was directed to transfer at least 300 medical corps officers to the Veterans Administration, this number to include those officers in the zone of the interior who were formerly employed by the Veterans Administration as civilians. Apparently about 100 men meeting the latter classification were so assigned and in addition some 200 others selected largely from among men who had been marked "limited services". Many of those thus assigned have protested and others are now protesting bitterly against these assignments on the ground that their enlistment was distinctly for military service and that assignment to the Veterans Administration cannot be thus characterized. Many physicians who have served with distinction in both the European and the Pacific theaters of operation are now indicating by com-

munications addressed to the headquarters of the American Medical Association the fear that they may be assigned on their return to the United States to service with the Veterans Administration. The unwillingness to serve with

ACTION of the American Medical Association protesting the assignment of medical officers to the Veterans Administration against their wishes, referred to in the accompanying article, substantiates the opinion expressed by *The Ohio State Medical Journal* editorially on page 456 of the May, 1945, issue.

It is hoped that the military authorities will do as the A.M.A. *Journal* recommends, "recognize the righteousness of the protests made by these medical officers against assignment to the Veterans Administration".

the Veterans Administration is based not only on their belief that this cannot be considered military service but also on the point of view that competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals.

## SUGGESTED BY MANY

"The Committee on Postwar Medical Service, which includes representatives of the American Medical Association, the American College of Surgeons, the American College of Physicians, the American Hospital Association, the Federation of State Medical Licensing Boards, the Association of American Medical Colleges, the Catholic Hospital Association, the Advisory Board for Medical Specialists and many other groups, after careful consideration of the problem involved urges that the Secretary of War, the Secretary of the Navy and all others concerned with the activities of physicians voluntarily enlisted in the armed forces recognize the righteousness of the protests made by these medical officers against assignment to the Veterans Administration. It is further urged that the needs of the Veterans Administration for physicians be met either by voluntary enrolment of men in the armed forces at the time of their

release from the service or by recruitment of medical personnel from civilian sources.'

#### UP TO MILITARY OFFICIALS

"The American Medical Association—and this statement is made wholly in explanation of a fact that should be obvious to every one—does not have authority to determine in any way the assignments of physicians in the armed forces. The officers of the Association would be hesitant to interfere in the making of decisions as to the assignments or transfer of men in the armed forces. The decisions as to how military personnel are to be utilized must rest with those who carry the responsibility for the ultimate results.

"This statement is made because many a medical officer has written to the headquarters of the American Medical Association actually demanding that the Association exert its influence to determine the decisions, not only of those responsible for the medical departments of the armed forces, but even of the Secretaries of War and Navy, of the Committees on Military Affairs of the legislative bodies and even of the President. The Board of Trustees and the officers of the Association have felt keenly, nevertheless, the responsibility that rests on them to present to those in authority the facts that should be given serious consideration in the making of decisions concerning medical personnel.

"Unfortunately, steps have not yet been taken by the Selective Service System for a continuing supply of physicians for the future. The medical schools are confronted at this moment with an insufficient number of men to fill their freshman classes in the years immediately to come. The Committee on Military Affairs of the Senate, having given serious and extended hearings to the Ellender bill, has failed to issue a statement of its reaction to that proposal. The time may yet come when those with the authority and the responsibility will have to answer to the people of the United States for a critical situation in the supply of medical service."

#### Dewey Vetoes Two Bad Bills

Governor Dewey has vetoed the two bills passed by the New York legislature permitting the granting of a medical license to graduates of any medical school in the United States. Commenting on this, *The Journal of the American Medical Association* says that "New York State and its governor merit congratulations. Again the standards of medical education and medical care have been saved by the courage and wisdom of a governor, after a legislature failed to recognize its obligation to the people."

#### Slight Increase in Death Rate

The death rate of the United States, reversing a long trend, rose slightly in 1943, even without counting the armed forces overseas. In announcing the 1943 figure, 10.9 per 1,000 estimated population, the U. S. Census Bureau gave two main reasons for the increase: Removal of great numbers of physically fit young persons to overseas duty left behind a greater proportion of older persons, and a bad influenza epidemic in 1943. The death rate in 1942 was 10.4, the lowest ever recorded in the United States.

The ten leading causes of death in 1943, their rate per 100,000 estimated population, and their change from 1942 were: heart diseases, 318.3, up 23.1 per cent; cancer and other malignant tumors, 124.5, up 2.4 per cent; cerebral hemorrhages, 95, up 4.8 per cent; nephritis, 74.1, up 1.7 per cent; pneumonia and influenza, 67.3, up 11.6 per cent; accidents other than from motor vehicles, 56.1, up 5 per cent; tuberculosis, 42.6, down 5 per cent; diabetes, 27.1 up 1.7 per cent; infants' premature birth, 25.8, unchanged; motor vehicle accidents, 17.8, down 3.4 per cent.

#### Neurological Subjects Discussed

The Cleveland Neurological Society held a meeting, May 16, at the Nurses' Home, Mercy Hospital, Canton, in conjunction with the Stark County Medical Society. The following program was presented: "Radar", Prof. F. J. Shollenberger, professor of physics, Mt. Union College, Alliance; "Treatment of Epidemic Meningitis", Dr. John A. Toomey, chief, department of contagious diseases, City Hospital, Cleveland; "Neuralgia of the Petrosal Nerve", Dr. W. James Gardner, chief, neuro-surgical division, Cleveland Clinic; "Mental Hygiene for Ohio", Dr. Attilio Laguardia, Columbus, assistant commissioner of mental diseases, State Department of Public Welfare. Officers of the Cleveland Neurological Society are: Lt. Comdr. Guy H. Williams, Jr., M.C., U.S.N.R., chairman, and Dr. Wilfred M. Gill, secretary.

#### Union District Society Meeting

The Union District Medical Association, composed of members of the Wayne-Union (Indiana) and Butler County (Ohio) medical societies, held a special meeting at the Richmond-Leland Hotel, Richmond, Ind., Thursday evening, April 26. Dr. William A. Davin, Hamilton, spoke on "The Diagnosis and Treatment of Cardiac Emergencies". Dr. G. F. Kempf, Lilly Research physician at the Riley Clinic, Indianapolis, discussed "Chemotherapy". The program was arranged by Dr. C. I. Stafford, Oxford, president of the association.



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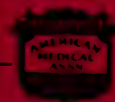
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**SEARLE**

RESEARCH IN THE SERVICE OF MEDICINE

# Questions and Answers About Navy Medical Corps, Need of Navy for Doctors and Regulations on Availability

**W**ITH MUCH of the hardest fighting of the war with Japan still to come, the Navy still needs additional medical officers.

Ohio physicians, even those over 45 years of age, who can be spared from civilian practice or from their present positions, should consider applying for a commission in the Navy Medical Corps, Reserve. However, availability clearance from Dr. Robert Conard, chairman, Ohio Procurement and Assignment Committee, War Manpower Commission, 1005 Hartman Theater Building, Columbus 15, Ohio, is necessary.

Physicians who can obtain availability clearance may apply through the Office of Naval Officer Procurement, 1249 Washington Boulevard, Detroit 26, Michigan, or through a similar office at 617 Vine Street, Cincinnati 2, Ohio.

Following are some typical questions and answers about the Navy Medical Corps, prepared by Navy Department, for the information of interested physicians:

## 1. What is the size of the Navy, the Medical Corps and the Nurse Corps?

As of January, 1945, the Navy comprised of approximately 3,300,000 officers and men, 12,500 Medical Officers, and 8,500 Nurses.

## 2. What rank can I expect?

The rank is determined by a candidate's professional qualifications, age, and academic seniority. Most doctors in the past year have been appointed as Lieutenants. Some entered the service as Lieutenants (j.g.) and also as Lieutenant Commanders. There are no Ensigns in the Corps.

## 3. What opportunities are there for advancement?

Reserve Medical Officers upon appointment are assigned a "running mate" with a member of the Regular Navy. When the "running mate" becomes eligible for consideration the Reserve Officer also becomes eligible for promotion.

There is one exception to this—and that is in regard to the elevation of Lieutenants (j.g.). Promotions are made in a block. For example, at the present time, officers who have been Lieutenants (j.g.) for 12 months are being considered for promotion to the rank of Lieutenant.

As a rule, an officer must be a Lieutenant for 18 months before he is eligible for promotion to Lieutenant Commander.

Similarly, to become a Commander or a Captain, he must have been in the next lower rank 24 months.

The ranks are made by Selection Boards composed of over 20 Admirals, Captains, and Commanders who regularly review officer qualifications for promotion.

## 4. What is the annual income for the rank which I might have upon entering the Navy?

Officers holding the rank of Lieutenant Commander receive \$3,000 base pay, \$1,260, rental allowance and \$766.50 subsistence allowance (with dependents), or a total of \$5,026.50 per year. Similarly, a Lieutenant receives \$3,991 and a Lieutenant (j.g.) \$3,411. In addition, all personnel are entitled to a \$1,500 income tax deduction, and all Naval activities provide, gratis, movies and many recreational facilities.

## 5. Is there a uniform allowance?

Yes. All officers receive \$250 for the purchase of uniforms.

## 6. Will I become a member of the U. S. Navy or the Reserve?

All appointments are now made to the Reserve. The statutory limit does not permit additional appointments to the Regular Navy. It is expected that future legislation will permit Reserve Medical Officers to transfer to the Regular Navy, under the requirements set for U.S.N.

## 7. What are the educational requirements to become a Navy Doctor with commissioned officer's rank?

A candidate must be a graduate of an approved medical school. However, graduates of medical schools not approved by the Council on Medical Education and Hospitals of the American Medical Association may apply for appointment. These candidates must demonstrate their professional qualifications by written, oral, and practical examinations prescribed by the Bureau of Medicine and Surgery. In addition to the above, candidates are asked to submit—

- a. A statement indicating the type and duration of intern training.
- b. Certificate of license to practice medicine.
- c. Certificate of membership in state or local medical society.
- d. Any evidence of training in specialty.

Note: a, b, c, d. above are not required of recent graduates applying for appointment as Lieutenant (j.g.).

## 8. What are the age requirements? Is there any difference for U.S.N. and U.S.N.R.?

The age bracket for entrance into the





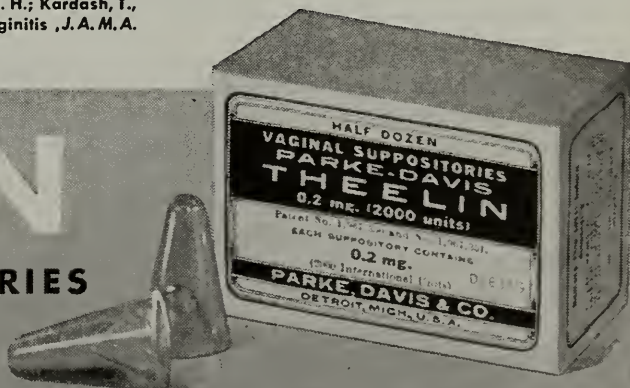
Although sulfathiazole and sulfadiazine have been found effective in the treatment of gonococcic vulvovaginitis, the danger of sensitization of the patient with these compounds makes an estrogen the drug of choice for the child.<sup>1</sup> Most physicians prefer to reserve the sulfonamides for the more serious diseases of childhood in which their use is imperative.

Available in small, conical-shaped suppositories for intravaginal administration, THEELIN produces temporary cornification of the vaginal epithelium, a favorable vaginal pH of 4.5 to 5.5, cessation of discharge, and negative smears for gonococci in two to four weeks.

Theelin Suppositories (Vaginal) contain 0.2 mg. Theelin in a glycono-gelatin base. Available in boxes of 6 and 50.

1. Compton, B. C.; Bieren, R. E.; Jones, E. G.; Inloes Jr., B. H.; Kardash, T., and Hundley, J. M.: Treatment of Gonococcic Vulvovaginitis, *J.A.M.A.* 127:6 (Jan. 6) 1945.

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Naval Reserve as a Medical Officer is 21 up to the 55th birthday. When appointments are open in the Regular Navy, the law states that a candidate "must be less than 32 at the time of acceptance of the appointment".

**9. What are the physical requirements?**

The same as for all other Naval Officers. The principal examinations are regarding eyes, blood pressure, heart, kidneys, and organic diseases. Consideration, however, is given where the nature of a disability is not likely to interfere with the performance of duties. No candidate should judge his own physical condition as to whether or not he is qualified. The final decision lies with the Bureau of Medicine and Surgery in Washington.

**10. If I qualify where will I probably be sent?**

As a rule, newly appointed Medical Officers are assigned to the Naval hospital or Naval Medical Department activity nearest home, for a period of indoctrinal training. This, of course, is subject to service needs.

**11. Can you tell me what type of duty to expect on my first assignment?**

The local Commanding Officer determines the duty. He is instructed to make every effort to utilize any special interest or training a Medical Officer may have.

**12. Where would I live while on duty?**

Most Medical Officers on duty in the United States are not required to live on a military reservation. They are given rental and subsistence allowances to cover their living in private residence. Officers who have no dependents are usually assigned to the bachelor's officers' quarters.

**13. May I take my family with me? What exactly are the provisions as to their housing, travel?**

Officers assigned to duty in the United States may take their families to their duty station. It is suggested that arrangements for housing be made prior to moving a family. The Navy makes a reimbursement for the cost of the family travel and moving of household effects.

**14. Do I ever have my choice of duty?**

The Navy attempts to offer a choice, in this way: each Medical Officer submits the names of three medical activities in the order of preference. Every effort is made to channel men to the duty of their choice, but under wartime conditions, this cannot always be the case.

**15. To what extent could I expect to practice along the lines of my chief interest or ability?**

Commanding Officers of all medical department activities endeavor to assign

medical officers to services of their choice, or in services which they have had previous training. This necessarily depends on local conditions.

**16. How long would it be from the time I am sworn in and the time I report to duty?**

Usually, after being sworn in you would receive orders to "proceed" to your duty station. This means that within four days, exclusive of travel time, you must report. If a doctor has made application he can check with Naval Officer Procurement and have several days "advance" notice of the acceptance of his application. The Navy recognizes that in most cases, candidates must make personal arrangements which require time and thus suggests that Procurement Offices assist candidates in letting them know the maximum time that can be taken before reporting for duty.

**17. What opportunities are there for special training?**

Such opportunity can come after the first tour of duty. Postgraduation instruction is not a first assignment, but all officers are encouraged to submit requests for instruction in aviation medicine, psychiatry, military government, etc., prior to completion of the first tour of foreign or sea duty.

**18. Is there a plan of Rotation of duty?**

Yes. After 18 months of foreign or sea duty, it is the policy of the Navy to assign Medical Officers to activities within the United States. After the first tour comes the opportunity for postgraduate work, and there are no time limit restrictions as to how long an officer remains in one activity within the United States.

**19. In my work, to what extent can I carry on medical practice along the lines to which I have been accustomed?**

In a certain number of instances, in both medicine and surgery, there are standard procedures. However, there is no real difference in the practice of medicine in civil life and in military life in diagnosis or therapeutic procedures.

**20. What do I do to secure my availability? If I am not 1-A, can I be so classified?**

The State Chairman, Procurement and Assignment Service, will give consideration to re-classification of physicians for military service, and also assist in contacts with Selective Service. The Office of Naval Officer Procurement can also assist on this in bringing a case before the State Chairman of P. and A. A physician who is classified 1-A, and is thus available for military service, should immediately contact Naval Officer Procurement.





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# Military Roster Increases; Total of 3,122 Ohio Doctors Now in Services; Those Receiving Promotions Listed

**M**ILITARY ROSTER of the Ohio State Medical Association totaled 3,122 as this issue of *The Journal* went to press—2,595 Army, 454 Navy, and 73 miscellaneous services.

The star prefix (\*) to some of the names added to the roster indicates that these men have been in service for some time but that this information has just reached *The Journal*. Those receiving promotions and a breakdown by counties, follow:

## NAMES ADDED TO MILITARY ROSTER

| Name                  | City             | Rank               |
|-----------------------|------------------|--------------------|
| Blagdon, Joseph Chas. | Cleveland.....   | Lt. Comdr., U.S.N. |
| *Brann, Joe E.        | Cincinnati ..... | 1st Lt., U.S.A.    |
| *Browning, John D.    | Toledo.....      | Lt. (j.g.), U.S.N. |
| *Butler, Donald       | Cincinnati ..... | 1st Lt., U.S.A.    |
| *Chase, Robert L.     | Akron .....      | 1st Lt., U.S.A.    |
| Duffner, Robert       | Cincinnati ..... | 1st Lt., U.S.A.    |
| *Espey, Hugh S.       | Xenia .....      | 1st Lt., U.S.A.    |
| *Gleitsman, Louis A.  | Akron .....      | 1st Lt., U.S.A.    |
| *Humphrey, David      | Cincinnati.....  | Lt. (j.g.), U.S.N. |
| Lemmon, James J.      | Akron .....      | 1st Lt., U.S.A.    |
| McDowell, Fletcher W. | Canton.....      | 1st Lt., U.S.A.    |
| Mikes, Frank Leo      | Cleveland.....   | Lt. (j.g.), U.S.N. |
| Minelli, Anthony J.   | Cleveland.....   | Lt. (j.g.), U.S.N. |
| Whiteman, Rex K.      | Akron.....       | 1st Lt., U.S.A.    |

## WIN PROMOTIONS

| Name                   | City                   | Rank             |
|------------------------|------------------------|------------------|
| Barth, Walter M.       | Cleveland .....        | Major, U.S.A.    |
| Boettner, John F.      | Cleveland.....         | Lt. Col., U.S.A. |
| Bonser, William A.     | Toledo .....           | Capt., U.S.A.    |
| Breneman, Roscoe H.    | Akron.....             | Capt., U.S.A.    |
| Craver, William Lee    | Columbus.....          | Lt., U.S.N.      |
| Cronin, John F.        | Cincinnati .....       | Lt. Col., U.S.A. |
| Curtzwiler, Francis C. | Toledo.....            | Lt. Col., U.S.A. |
| D'Amore, A. R.         | Youngstown.....        | Capt., U.S.A.    |
| Evans, Harrison S.     | Columbus.....          | Lt. Col., U.S.A. |
| Fergus, Joseph A.      | St. Paris.....         | Capt., U.S.A.    |
| Fischbach, Wm. Morris  | Cincinnati.....        | Lt., U.S.N.      |
| Good, Charles F.       | Cleveland.....         | Lt. Col., U.S.A. |
| Hamilton, Paul V.      | Cincinnati.....        | Lt. Col., U.S.A. |
| Hamman, R. H.          | Waterville.....        | Capt., U.S.A.    |
| Hankinson, D. O.       | Columbus.....          | Major, U.S.A.    |
| Heaver, Robert J.      | Youngstown .....       | Capt., U.S.A.    |
| Hubbs, Ralph E.        | Cleveland.....         | Major, U.S.A.    |
| Krisko, Michael J.     | Cleveland.....         | Capt., U.S.A.    |
| Lacey, Henry B.        | Columbus.....          | Lt. Col., U.S.A. |
| Lytte, Robert P.       | Cleveland.....         | Lt. Col., U.S.A. |
| McCauly, W. C.         | Cleveland.....         | Col., U.S.A.     |
| McGuire, Johnson       | Cincinnati.....        | Col., U.S.A.     |
| Meltzer, Jack          | Cleveland .....        | Major, U.S.A.    |
| Nichol, Arthur D.      | Shaker Heights.....    | Lt. Col., U.S.A. |
| Parke, G. K.           | Akron.....             | Major, U.S.A.    |
| Pelton, Bernard L.     | Toledo.....            | Lt. Col., U.S.A. |
| Pugh, Luther S.        | Perrysburg.....        | Capt., U.S.A.    |
| Schaffer, Allan Lewis  | Cleveland Heights..... | U.S.A.           |
| Schnitker, Maurice     | Toledo.....            | Lt. Col., U.S.A. |
| Smith, Kenneth D.      | Columbus.....          | Lt. Col., U.S.A. |
| Solomon, Walter M.     | Cleveland.....         | Lt. Col., U.S.A. |
| Storer, Wm. E.         | Middletown.....        | Capt., U.S.A.    |
| Updegraff, Ralph K.    | Cleveland.....         | Capt., U.S.A.    |
| Wayman, T. Brent       | Cincinnati.....        | Major, U.S.A.    |
| Williams, John A.      | Cincinnati.....        | Major, U.S.A.    |

## TABULATION BY COUNTIES

|                |     |                  |     |                |      |
|----------------|-----|------------------|-----|----------------|------|
| Adams .....    | 2   | Guernsey ....    | 7   | Muskingum ..   | 9    |
| Allen .....    | 39  | Hamilton .....   | 512 | Noble .....    | 1    |
| Ashland .....  | 12  | Hancock .....    | 12  | Ottawa .....   | 9    |
| Ashtabula ..   | 18  | Hardin .....     | 7   | Paulding ..... | 2    |
| Athens .....   | 11  | Harrison .....   | 4   | Perry .....    | 4    |
| Auglaize ....  | 6   | Henry .....      | 3   | Pickaway ..... | 5    |
| Belmont .....  | 15  | Highland .....   | 7   | Pike .....     | 2    |
| Brown .....    | 1   | Hocking .....    | 4   | Portage .....  | 4    |
| Butler .....   | 33  | Holmes .....     | 2   | Preble .....   | 7    |
| Carroll .....  | 2   | Huron .....      | 17  | Putnam .....   | 6    |
| Champaign ..   | 9   | Jackson .....    | 1   | Richland ..... | 37   |
| Clark .....    | 37  | Jefferson .....  | 28  | Ross .....     | 22   |
| Clermont ..... | 9   | Knox .....       | 10  | Sandusky ..... | 12   |
| Clinton .....  | 8   | Lake .....       | 19  | Scioto .....   | 19   |
| Columbiana ..  | 12  | Lawrence .....   | 7   | Seneca .....   | 11   |
| Coshocton ...  | 4   | Licking .....    | 17  | Shelby .....   | 7    |
| Crawford ....  | 9   | Logan .....      | 8   | Stark .....    | 102  |
| Cuyahoga ....  | 786 | Lorain .....     | 39  | Summit .....   | 164  |
| Darke .....    | 6   | Lucas .....      | 181 | Trumbull ..... | 28   |
| Defiance ....  | 4   | Madison .....    | 6   | Tuscarawas ..  | 20   |
| Delaware ....  | 7   | Mahoning .....   | 140 | Union .....    | 2    |
| Erie .....     | 11  | Marion .....     | 16  | Van Wert ..... | 11   |
| Fairfield .... | 9   | Medina .....     | 13  | Vinton .....   | 2    |
| Fayette ....   | 2   | Meigs .....      | 3   | Warren .....   | 4    |
| Franklin ....  | 256 | Mercer .....     | 6   | Washington ... | 8    |
| Fulton .....   | 6   | Miami .....      | 15  | Wayne .....    | 13   |
| Gallia .....   | 5   | Monroe .....     | 0   | Williams ..... | 8    |
| Geauga .....   | 4   | Montgomery...163 |     | Wood .....     | 19   |
| Greene .....   | 8   | Morgan .....     | 3   | Wyandot ....   | 3    |
| Total .....    |     |                  |     |                | 3122 |

## Ohio Chapter Wins Prize

An award of \$50.00 in war bonds was made to the Ohio Alpha Chapter of Alpha Epsilon Delta, national honorary premedical fraternity, at the Ohio State University, Columbus, for the prize-winning essay, "A Plan for Postwar Pre-medical Education" which the chapter submitted in an essay contest conducted by the fraternity's magazine, *The Scalpel*. On April 13, at a meeting open to all premedical students, the award was presented by Dr. Maurice L. Moore, editor of *The Scalpel* and national secretary of Alpha Epsilon Delta. Dr. Moore, director of the organic research division of Frederick Stearns & Company, Detroit, delivered an illustrated lecture on "Sympathomimetic Agents" at the presentation meeting.

**Cincinnati**—In recognition of his many years of devoted service to the afflicted and to civic improvement, Dr. E. W. Mitchell was elected an honorary member of the board of trustees of the Anti-Tuberculosis League. Dr. C. A. Neal, president of the League for five years, was presented with a clock from the Board and a cigaret box that William S. Groom, president of the Public Health Federation, made in his workshop.

**Dayton**—"Safety Organization", was the subject of an address made by Dr. M. M. Shafer, medical director of the Frigidaire Division of the General Motors Corporation, during the second session of the Industrial Safety Training Course at the Chamber of Commerce.



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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### GOVERNMENT MEDICINE ADVOCATES GET A REAL JOLT — — BUT

Some of those who have been such strong proponents of governmental medical and health programs have found the criticism which has been leveled at the Veterans Administration because of existing conditions in some of the administration's hospitals a bitter pill to swallow.

If the charges which have been made are true, the medical programs in some of the Veterans Administration facilities have many, if not all, of the defects which the medical profession has warned are inevitable in government administered medical care programs.

Albert Deutsch, writer for *P. M.*, who has been a rabid advocate of federalized medicine and a bitter critic of organized medicine, recently said: "If this is an example of so-called Federal medicine, I want none of it"

Proponents of compulsory governmental medical programs also received a shock in California and Michigan where the legislatures refused to enact such measures.

Those who contend that the public wants regimented medical services haven't the proof for their conclusions. Nevertheless, the public is interested—very much so—in programs which will spread the risk and distribute the costs of medical care on a prepayment basis. The ultimate conclusion would appear to be that it wants the job handled through voluntary, unofficial programs under the direct guidance of the medical profession. The present attitude of the public is that it is willing to give the profession reasonable time to do the job but that it expects an early end to bickering and delay. In our opinion, the profession had better accept this challenge—and in a hurry.

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### REALISTIC APPROACH TO THE HOSPITAL BED PROBLEM

In many areas of the state the situation growing out of a shortage of hospital beds is getting progressively worse. Hospitals don't like it; neither do the doctors, to say nothing of the attitude of patients. But, complaining will not solve the problem.

One attack on this condition would be a real effort to shorten the average hospital stay. Obviously, the physician is one of the key figures. He should encourage patients to leave the hospital just as soon as they can do so with safety. Likewise, he should refrain from certifying to

hospitals those who can be taken care of at home.

Moreover, what better time has there been for stimulating public interest in hospital building programs? Perhaps actual work can not be started immediately but certainly preliminary plans can be completed.

The public has become hospital-minded. Hospital occupancy is probably going to be larger in the future than in the past. In the end, the answer is not an effort to deprive patients of hospital accommodations when needed but expansion of hospital facilities when and where needed and elimination of abuses which exist.

---

### COOPERATION BETWEEN DOCTORS AND RED CROSS ON FURLOUGHS

Red Cross Chapters have the responsibility of acting as an intermediary between military authorities and the families of service men on the matter of obtaining leaves for a service man when there is serious illness among members of his family. Obviously, the attending physician plays a very important part in this worthy undertaking. There must be complete cooperation between the Red Cross, physicians, military authorities and families if this plan is to work without abuse and misunderstandings.

In our opinion a proposal submitted to the Mahoning County Red Cross Chapter by the Mahoning County Medical Society, covering the physician's responsibility as well as that of the Red Cross on this matter, is sound and practical. It has been approved by the Mahoning County Red Cross Chapter and is outlined below for the guidance of other county medical societies in their negotiations with Red Cross officials:

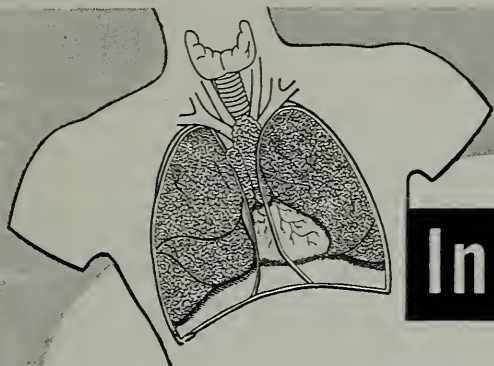
"1. If a medical problem (medical or surgical) is considered serious, the medical attendant in charge should so notify the Red Cross so that the person in the Armed Services so affected shall be given a leave of absence from duty to return home because of this family disability if the service person is not in foreign duty (that is duty outside the Continental U. S.).

"2. If the case is understood by the medical attendant not to be of a serious nature, he or she will so notify the Red Cross to that effect and will make it known to the Red Cross representative that it is not necessary for a furlough because of this medical problem.

"3. If the case has been of a chronic nature and other complications develop and if the medical attendant is in doubt as to its outcome, the medical attendant should give the benefit of the doubt to the person requesting the furlough and aid the Red Cross in securing the requested furlough.

"4. The Medical Profession should not give





## In the Pneumonias

**D**URING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).<sup>\*</sup> Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

<sup>\*</sup>Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, *Pennsylvania M. J.* 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, *Am. J. Dis. Child.* 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, *Pennsylvania M. J.* 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, *Hawaii M. J.* 3:272 (July-Aug.) 1944.

## PENICILLIN - C. S. C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

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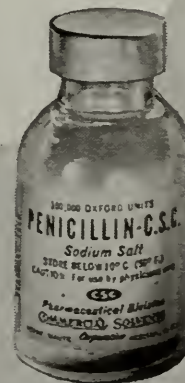
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aid to families at home for the release or forgiveness of armed force personnel on physical conditions that cannot be confirmed by the medical attendant.

"5. The Red Cross worker after contacting the medical attendant should not state bluntly that the physician in charge of the case in question has refused to give his or her consent to bring the person home because of this illness but should use as much diplomacy as possible, leaving some of the responsibility to the commanding office of the service personnel. This may be difficult at times but the medical attendants are complaining about the bluntness with which these matters are sometimes handled and thrown back on his or her shoulders."

#### EVERY DOCTOR SHOULD HELP P.T.A. IN SUMMER ROUND-UPS

**WANTED:** Thousands of boys and girls in Ohio—just six years of age and about to enter the First Grade of school in September—able to meet this new experience, physically fit and mentally alert.

If the Ohio Congress of Parents and Teachers had the inclination to place a classified advertisement regarding its Summer Round-Up of Children, it might decide on wording similar to the above which describes the "hope" and the "want" underlying this program of the P.T.A.

The Health Service Department of the Ohio Congress of Parents and Teachers, of which Mrs. L. D. Martin, Toledo, is chairman, is completing its plans for the 1945 pre-school clinics.

Obviously, if this year's program is to be as successful as those of the past, there must be full cooperation by all community health services—especially active participation by members of the medical profession.

Again the Ohio Congress of Parents and Teachers is appealing to local medical societies and other organizations interested in health to assist in setting up programs for the examination and immunization of pre-school children and whereby recommendations can be made to parents for the correction of remedial defects in their youngsters.

Quoting from Mrs. Martin's statement on this request:

"Again the parents and teachers are appealing to the doctors of the state to add a few hours to their already heavy schedule and to give their cooperation to this project, either by examining in their offices (preferably) or in clinics. No one realizes better than they that 'an ounce of prevention is worth a pound of cure' and that a brief time spent in examining and immunizing a child may save that child's life or hours of sickness with resulting anxiety on the part of the parents and hours of extra service on the part of the doctor."

The medical profession of Ohio always has met this responsibility. We know that doctors in all communities will again rally to the aid of the parent-teacher organizations in this worthy

project. The war against disease must go on. The main attack must be at the infant and pre-school levels.

#### FIGURES SHOW INTEREST IN INDUSTRIAL HEALTH WORK

According to a recent report of the Committee on Postwar Medical Service of the American Medical Association, about one-fourth, or 4,215, of the medical officers who answered a questionnaire indicated that they wished to enter the field of industrial medicine when they return to civilian practice.

Of the 4,215 expressing their desire, 863 favored full-time positions and 484 want special training in this field.

These figures are indicative of the increasing interest in and importance of this specialty. They should serve to stimulate greater interest on the part of Ohio medical societies in putting into effect all or part of the program which has been recommended by the Committee on Industrial Health of the Ohio State Medical Association.

There is little doubt but what industrial health programs will become more and more popular as industry and workers have learned the value of them during the war years. They will need adequate medical guidance and supervision on an organized scale. Simply supplying physicians will not do the job. It is the responsibility of medical societies to give such men a concrete program—tools with which to work, in addition to the special training they may receive before taking on the job.

#### SUPPORT OF ALL DOCTORS FOR ELLENDER BILL URGENT

In the April issue of *The Journal*, Ohio physicians were urged to write to Senators Taft and Burton, requesting them to support Senate Bill 637 by Senator Ellender of Louisiana, pending before the Senate Committee on Military Affairs.

The Ellender bill provides for the deferment of qualified premedical students and the assignment of acceptable men in the armed forces to premedical and medical schools.

Unless this proposal, or one comparable, is enacted the greatest crisis ever faced by medical education will occur in 1946 when a desperately inadequate number of qualified students will be available for admission to freshmen medical classes.

Under present Selective Service regulations medical schools will have to recruit incoming freshmen in 1946 from women, men under 18 or who are physically disqualified, and discharged veterans. It has been estimated that these groups will not supply more than 2,000 qualified students, as compared with a normal admission of about 6,000. A survey of eight



# "don't smoke..."

*IS ADVICE HARD FOR  
PATIENTS TO SWALLOW!*

May we suggest, instead,  
*SMOKE "PHILIP MORRIS"?*  
Tests\* showed 3 out of every  
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cleared on changing to  
PHILIP MORRIS. Why not  
observe the results for  
yourself?

\*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

large universities revealed that only 42 veterans were enrolled there as premedical students who would become available before 1947. Ordinarily these schools provide 800 to 900 medical school freshmen annually.

Unfortunately, the Army, Navy and Selective Service have refused to concede that a serious situation exists in medical education. It would seem, therefore, that the medical profession, supported by public sentiment, must look to the Congress for corrective action.

Write to Senators Taft and Burton and get influential persons in your community to do so after you have given them the facts. Do it now, as favorable action by the Congress as soon as possible is imperative.

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### RENEWAL OF TRANSIENT FARM LABOR MEDICAL PROGRAMS SUGGESTED

Supplying medical care for hundreds of transient farm workers who will be brought into Ohio during the Summer months will again be a responsibility of Ohio physicians.

Under a general policy worked out between the Ohio State Medical Association and the Agricultural Extension Department, Office of Emergency Farm Labor, Ohio State University, the situation was handled efficiently and satisfactorily in the Summer of 1944. This was due largely to the cooperation of many County Medical Societies.

Suggestions as to how this program might be carried on in any county were published in the June, 1944, issue of *The Ohio State Medical Journal*. This article should be reviewed by County Society officers as a guide for activities this year.

A report from the extension department reveals that the Lake County Medical Society recently offered to cooperate and suggested a program which will permit participation by all physicians in the county on a free-choice, fee-for-service basis, use of the minimum fee schedule of that county, and application of the Workmen's Compensation Medical Fee Schedule in unusual cases, surgery, etc. The arrangement also suggested that patient's be provided with notices authorizing the services.

This is merely an example of what the plan might be in one county. Other societies may desire different arrangements. The main point is that some arrangement between the medical society and the local County Farm Agent should be worked out in each county where transient laborers are being used.

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The American Therapeutic Society has cancelled its meeting scheduled to be held June 15 at Atlantic City.

## News Notes

**Canton**—McKinley Pavilion, the \$758,000 addition to Aultman hospital has been dedicated. Built with Federal Government aid under the Lanman Act, the four-story addition includes four air-conditioned operating rooms, service facilities, central supply room, a laboratory, pharmacy, kitchen and dining room. Its 120 beds increased the hospital's bed capacity to 270. A new nurses' home under construction will provide dormitories for 50 nurses and teaching facilities for 200 student nurses.

**Cincinnati**—Dr. Bernard Schwartz, director of the Max Stern Heart Station for the Study of Rheumatic Heart Disease, recently addressed school physicians and nurses on "Rheumatic Fever".

**Cleveland**—"Socialized Medicine" was discussed by Dr. Ralph Herz and Dr. Milton B. Cohen at a meeting of the Laymen's League of the First Unitarian Church.

**Cleveland**—Dr. Samuel L. Bernstein celebrated his 50th year in the practice of medicine by working as usual.

**Dayton**—Dr. Bert A. Rose has been re-elected to a two-year term on the board of directors of the Montgomery County Tuberculosis Association.

**Forest**—Dr. W. H. Mundy, veteran Hardin County physician, has been re-elected to the county health board.

**Gallipolis**—Dr. Charles E. Holzer spoke on "Cancer" at a meeting of the Middleport Women's Club.

**Middletown**—The importance of early diagnosis and treatment of tuberculosis was discussed by Dr. David Gerber at a meeting of the Franklin Rotary Club.

**Piqua**—Dr. Albert J. Bausman recently celebrated the Golden anniversary of his entrance into the practice of medicine.

**Toledo**—"Economic Peace in Our Time", was the subject of an address made by Dr. Joseph Muenzer at a meeting of the Fayette Mother's Club.

**Toledo**—Dr. R. H. Beiswanger spoke on "Cancer" at a meeting of the students of Bowling Green State University.

**Wellington**—Dr. and Mrs. C. B. Gregg recently observed the 50th anniversary of their marriage. Dr. Gregg has completed 50 years in the practice of medicine here.





## By the light of the moon

Might as well expect the average child to get adequate vitamin D "by the light of the moon" as to depend wholly on the sun. Even in the summertime when the sun is shining many children are not as exposed to it as we might think. Cloud filtration and the uncertainty of adequate exposure even in such sunny areas as California<sup>1</sup> have led leading nutritionists to the conclusion that supplementation with vitamin D is essential. Essential as long as growth persists—through infancy, childhood and adolescence.

Regardless of season or geography, Upjohn makes available convenient, palatable, highly potent natural vitamin preparations to meet the varied clinical requirements of earliest infancy through late childhood.

## Upjohn Vitamins

1. Am. J. Dis. Child. 54:1227, 1937.



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FINE PHARMACEUTICALS SINCE 1886

# Annual Hospital Census of A.M.A. Contains Important Data on Services and Facilities; Postwar Training

THE Twenty-Fourth Annual Hospital Census conducted by the Council on Medical Education and Hospitals of the American Medical Association, as published in detail in the March 31, 1945, issue of *The Journal of the A.M.A.*, has a wealth of statistical information and pertinent observations on hospital service and medical education in the United States during 1944.

Summarizing the report in an editorial, *The Journal* said: "Although operating under difficult conditions, the hospitals continue to render efficient service to the sick and injured, and should be commended on their resourcefulness and skill in meeting the increased demands of the wartime period".

Included in the 1944 study are 6,611 registered hospitals, 44 less than the number reported in 1943. The report points out that in the Federal classification there was a net loss of 29, but the other governmental institutions gained 7 and the nonprofit organizations 25. As in the previous year, the number of proprietary hospitals was again reduced, this time by 47. Since the last report a total of 119 new institutions have been admitted to the Hospital Register, whereas 163 have been closed or transferred to the unclassified file.

## GAIN IN CAPACITY

Although the number of hospitals was decreased there was not a corresponding loss in bed capacity. On the contrary a definite increase occurred through the development of new hospital facilities and the expansion of existing services. The total capacity is now 1,729,945 beds, a gain of 80,691 in the last year. This is in contrast with the rapid expansion of 1943, when 265,427 beds were added; however, the present gain exceeds the increase of 59,446 in 1942 and is far above the average annual expansion of 26,000 beds reported in the period 1909-1940.

The increase in bed capacity again was confined almost entirely to the Federal hospitals which now have 551,135 beds as compared with 476,673 in 1943. The church, related and other nonprofit hospitals showed a gain of 6,007 beds, the county institutions 2,393 and municipal hospitals 1,808. The report says that it is of interest to note that the growth recorded in 1944 is the equivalent of a new 220-bed hospital for each day of the year.

## ADMISSIONS INCREASE

The most striking feature of the present survey is the continued expansion of inpatient hospital care. This is evident in the unprecedented report of 16,036,848 admissions in 1944 exclusive

of outpatients and newborn infants. The number of admissions in 1934 was 7,147,416, indicating that the hospital service in the United States was more than doubled in the last ten years.

The tremendous volume of service rendered by hospitals under present wartime conditions is indicated also in the daily patient load, which averaged 1,299,474 in 1944 exclusive of newborn infants. On the basis of 366 days in the year, this represents a total of 475,607,484 patient days, an increase of 16,757,224 over the 1943 report. In addition to the number of patients listed, the registered hospitals in the United States gave care to 1,919,976 newborn infants in 1944. This figure is practically identical with the total reported last year, the reduction being 4,615. This reduction becomes more significant when compared with the increases of 265,659 hospital births in 1942 and 253,992 in 1943. In the twelve months' period covered by the report the hospital birth rate may be reported as one live baby every 16.4 seconds.

## AVERAGE LENGTH OF STAY

The average length of stay per patient in governmental hospitals in 1944 was 20.3 days, the range extending from 10.9 days in the city-county institutions to 22 in the Federal classification. The average length of stay per patient in nongovernmental hospitals last year was 9.8 days in the nonprofit group and 7.6 days in the proprietary group. Although the nongovernmental hospitals have only 22 per cent of the total bed capacity they received 59.2 per cent of all admissions in 1944.

## OHIO HOSPITALS REGISTERED

The Council registered 237 Ohio hospitals in 1944, one more than in 1943. Their bed capacity was 63,313; bassinets, 3,706, as compared with 59,616 and 3,608, respectively, in 1943. Patients admitted numbered 642,530, a slight increase over 626,184, the 1943 total. The average daily census increased from 51,384 in 1943 to 53,639 in 1944.

Ohio hospitals are classified by control as follows: Federal, 11; state, 23; county, 28; city, 20; church, 44; nonprofit associations, 93; individual and partnership, 10; corporations, 8, a total of 237, of which 152 are nongovernmental.

Following is the classification of Ohio's hospital facilities by type of service: general, 154; nervous and mental, 24; tuberculosis, 22; maternity, 7; industrial, 1; children's, 3; orthopedic, 3; isolation, 1; convalescent and rest, 4; hospital departments of institutions, 15; others, 3.

Technical personnel employed in Ohio hospitals



# Peptic Ulcer Prophylaxis

... "ONE OF THE MOST IMPORTANT PHASES OF ULCER MANAGEMENT"

THE LITERATURE<sup>1-4</sup> stresses the high incidence of recurrence in peptic ulcer and the need of constant vigil against flare-up. A return to the ulcer regimen—special diet, rest, antacids, etc.—is said to be particularly advisable during spring and autumn<sup>4</sup> and following emotional storms.<sup>5</sup>

Phosphaljel\*, with its antacid, astringent and demulcent properties, provides an appropriate adjunct to such peptic ulcer prophylaxis. The value of a good buffering agent "is almost self-evident"<sup>6</sup> for this purpose, as well as for more resistant conditions, such as gastrojejunal ulcer, which have also been found to respond to Phosphaljel therapy<sup>7</sup>.

\*Reg. U. S. Pat. Off.

## PHOSPHALJEL

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1. Bockus, H. L.; Gastro-Enterology 1:471, 1943, W. B. Saunders Co., Phila.
2. Hurst, A.; Practitioner 152:193, 1944.
3. Berk, J. E.; J. Med. Soc. N. J. 41:365-370, 1944.
4. Rehfuess, M. E.; Indigestion, Its Diagnosis and Management, Phila. W. B. Saunders Co., 1943, pp. 241-243.
5. Alvarez, W. C.; Gastroenterology, 2:65-67, 1944.
6. Selye, H. and MacLeon A.; Amer. J. Dig. Dis. 11:319-322, 1944.
7. Fauley, G. B., et al.; Arch. Int. Med. 67:563-578, 1941.



is classified as follows: laboratory technicians, 558 full time and 88 part time; X-ray technicians, 284 full time and 67 part time; dietitians, 316 full time and 35 part time; physical therapists, 119 full time and 22 part time; pharmacists, 120 full time and 27 part time; medical record librarians, 166 full time and 47 part time; medical stenographers, 349 full time and 42 part time; occupational therapists, 70 full time and 17 part time; nurse anesthetists, 134 full time and 10 part time.

#### APPROVED FOR INTERN TRAINING

The following Ohio hospitals, numbering 42, are approved for internship: City, Peoples and St. Thomas Hospitals, Akron; Aultman and Mercy Hospitals, Canton; Bethesda, Christ, Cincinnati General, Deaconess, Good Samaritan, Jewish and St. Mary's Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Lutheran, Mt. Sinai, St. Alexis, St. John's, St. Luke's, St. Vincent's Charity, and University Hospitals, Cleveland; Grant, Mt. Carmel, St. Francis, Starling Loving University and White Cross Hospitals, Columbus; Huron Road Hospital, East Cleveland; Good Samaritan, Miami Valley and St. Elizabeth's Hospitals, Dayton; Lakewood, Lakewood; Memorial and St. Rita's Hospitals, Lima; City Hospital, Springfield; Maumee Valley, Mercy, St. Vincent's, Riverside, Toledo Hospitals, Toledo; Youngstown and St. Elizabeth's Hospitals, Youngstown.

#### SPECIALIZED TRAINING

All hospitals approved for internship are automatically accredited for mixed residency training. Hospitals in Ohio approved for residencies in specialties number 44. They are: Children's, People's, City and St. Thomas Hospitals, Akron; Mercy Hospital, Canton; Christ, Children's, Cincinnati General, Deaconess, Good Samaritan, Dunham, Jewish, Longview State Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Glenville, Grace, Mt. Sinai, St. Alexis, St. John's, St. Luke's, St. Vincent's Charity, Woman's, and University Hospitals, Cleveland; Children's, Columbus State, Starling Loving University, St. Francis, Franklin County Tuberculosis, and White Cross Hospitals, Columbus; Miami Valley Hospital, Dayton; Huron Road Hospital, East Cleveland; Army Regional Hospital, Fairfield; Mercy Hospital, Hamilton; General Hospital, Mansfield; Massillon State Hospital, Massillon; Maumee Valley, Mercy, Toledo, and St. Vincent's Hospitals, Toledo; Cuyahoga County Tuberculosis Sanatorium, Warrensville; Harding Sanitarium, Worthington; and St. Elizabeth's and Youngstown Hospitals, Youngstown.

#### SCHOOLS FOR TECHNICIANS

The report of the Council contains a list of 245 schools approved for the training of clinical

laboratory technicians and includes the following in Ohio: City and People's Hospitals, Akron; St. Thomas Hospital, Akron; Good Samaritan Hospital, Cincinnati; Mt. Sinai Hospital, Cleveland; University Hospitals, Cleveland; Mt. Carmel Hospital, Columbus; Starling Loving University Hospital, Columbus; Miami Valley Hospital, Dayton; Huron Road Hospital, East Cleveland; Mercy Hospital, Toledo; Toledo Hospital, Toledo; St. Vincent's Hospital, Toledo; Youngstown Hospital, Youngstown.

Among the 115 schools approved for X-ray technicians are the following in Ohio: City Hospital, Akron; Cincinnati General Hospital, Cincinnati; City, Mt. Sinai and University Hospitals, Cleveland; Good Samaritan and Miami Valley Hospitals, Dayton; Huron Road Hospital, East Cleveland; Youngstown Hospital, Youngstown.

Ohio State University, Columbus, is one of 17 schools approved for the training of occupational therapy technicians.

The Cleveland Clinic Foundation Hospital, Cleveland, is included in the list of 32 schools approved for teaching physical therapy technicians.

### Comments and Data on Postwar Graduate Training

On the subject of Postwar Graduate Training the report contained the following information and comments:

"The pattern of medical education in the United States has been modified in recent years incident to wartime needs. The principal change is in the acceleration of training, affecting not only the undergraduate years but also the advanced periods of internships, assistant residencies and residencies. While every effort has been made to produce competent medical personnel at the maximum rate consistent with high quality, it is evident that educational activities have often been hampered by increased teaching loads and the depletion of faculties of medicine and hospital staffs.

"As regards internships one must necessarily conclude that the reduced period of nine months does not afford the young graduate an adequate opportunity to consolidate his theoretical knowledge and obtain sufficient experience in clinical practice. Since assistant residencies and residencies have also been curtailed, it is obvious that one of the major responsibilities of the medical profession is the development of adequate facilities and opportunities for the continued training of physicians returning from military service.

#### HOSPITALS POLLED

"Considerable thought and study have already been given to this problem. As early as November, 1942, the Council on Medical Education





## ERYSIPELOID

(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by *Erysipelothrix rhusiopathiae*. It is observed rather frequently among those brought into contact with animals and fish.

Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

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Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.

**REDUCED REACTIONS**—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* anti-serum for human use, in which the volume is reduced as much as 80%.



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and Hospitals began to make a careful investigation of the educational facilities in the graduate and postgraduate fields. Nearly 1,300 hospitals, medical schools and other agencies were requested to furnish information regarding training programs available or under consideration in relation to the postwar period.

"The preliminary report on this study, published in *The J.A.M.A.*, Jan. 1, 1944, showed that constructive planning was already under way and that all institutions concerned were anxious to cooperate to the fullest extent. It was estimated at that time that with a normal civilian complement of 5,500 residents the approved hospitals may be called on to furnish a total of 12,000 to 13,000 residencies after the war.

"More recent studies have been carried out in collaboration with the Committee on Postwar Medical Service. This committee, with the cooperation of the Surgeons General of the Army, Navy and Public Health Service, has contacted all medical officers to ascertain their postwar educational desires. Analyses of the first thousand returns were published by Lieut. Col. Harold C. Lueth, then Surgeon General's Liaison Officer, in *The J.A.M.A.*, Aug. 19, 1944, and by the Council on Medical Education and Hospitals in *The J.A.M.A.*, Sept. 23, 1944. On the basis of these reports it was estimated that approximately 10,260 of the physicians in military service will request formal full-time training of nine to thirty-six months' duration. While the number of resi-

pathology, radiology and psychiatry and neurology. If it is assumed that the demobilization of medical officers will extend over a period of two years there will be approximately 4,590 additional residencies needed to supplement the number regularly available. It should be noted, however, that this estimate may require further modification in the light of Colonel Lueth's recent analysis of the 21,000 returns that have been received on the questionnaires sent by the Committee on Postwar Medical Service.

#### RESIDENCIES AVAILABLE

"Last November the Council directed a communication to all approved intern and residency hospitals requesting their aid in the development of assistant residencies, residencies, fellowships, full-time graduate externships, full-time refresher courses and basic medical science instruction as requested by medical officers. Replies have now been received from 256, or approximately 25 per cent, of the civilian hospitals approved by the Council for intern and/or residency training. These reports indicate that 1,752 additional residencies can be provided in the various divisions of medicine and surgery, including 1,042 in residency services already approved by the Council.

"From the data contained in the preceding table it seems probable that the hospital facilities will be adequate to meet the anticipated demand for postwar graduate training. The estimated requirements in anesthesia, dermatology, neurosurgery, pathology, plastic surgery, neurology and psychiatry and radiology can practically be fulfilled by the group that has already reported. In most of the other specialties the required facilities will no doubt be available when an additional 25 to 50 per cent of the hospitals have replied. There may be one exception, however, in the general surgical field, in which 263 places have now been reported in relation to the estimated need of 1,386.

"Few hospitals have supplied information regarding mixed residency training, but since all approved internship hospitals are likewise accredited for general residencies, there should be no considerable difficulty in providing the number of general training courses requested by medical officers.

#### REFRESHER COURSES

"Twenty-two residencies in hospital administration were included in the present reports, 3 in industrial medicine and 10 in public health. Eighty-two hospitals will develop refresher courses, whereas 65 can accommodate 283 full-time externships in outpatient departments and inpatient hospital services. In 41 institutions basic science instruction will be supplied by the hospitals themselves; in 35 others such training

#### Development of Postwar Residency Programs

| Residencies<br>Desired                        | Estimated<br>Requirement<br>(2 Year De-<br>mobilization) | Additional<br>Residences<br>Available in<br>25% of the<br>Approved<br>Hospitals |
|-----------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------|
| Anesthesiology .....                          | 53                                                       | 58                                                                              |
| Dermatology and syphilology....               | 36                                                       | 34                                                                              |
| General training .....                        | 539                                                      | 69                                                                              |
| Internal medicine and<br>subspecialties ..... | 669                                                      | 322                                                                             |
| Neurosurgery .....                            | 16                                                       | 33                                                                              |
| Obstetrics-gynecology .....                   | 558                                                      | 167                                                                             |
| Ophthalmology .....                           | 216                                                      | 55                                                                              |
| Orthopedics .....                             | 127                                                      | 85                                                                              |
| Otolaryngology .....                          | 274                                                      | 65                                                                              |
| Pathology .....                               | 131                                                      | 112                                                                             |
| Pediatrics .....                              | 184                                                      | 86                                                                              |
| Plastic surgery .....                         | 12                                                       | 13                                                                              |
| Psychiatry and neurology.....                 | 149                                                      | 224                                                                             |
| Radiology .....                               | 99                                                       | 104                                                                             |
| Surgery .....                                 | 1,386                                                    | 263                                                                             |
| Urology .....                                 | 111                                                      | 62                                                                              |
| Other .....                                   | 30                                                       | —                                                                               |
| Totals .....                                  | 4,590                                                    | 1,752                                                                           |

dencies may need to be doubled after the war, the degree of expansion is not uniform in all fields. An increase of 110 to 120 per cent, for example, may be required in surgery, otolaryngology and obstetrics-gynecology, 50 to 90 per cent in ophthalmology, urology, internal medicine, orthopedics and pediatrics, and 30 to 40 per cent in



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will be available in affiliation with medical schools. Approximately 185 hospitals can provide quarters, meals and laundry, with an additional monthly stipend in 165. In some cities regional plans are in process of development in which the graduate program of medical schools will be utilized in coordination with allied hospital services. Systematic planning of this type will no doubt play a significant part in the organization of acceptable postwar graduate training programs.

"The Council, in cooperation with the Committee on Postwar Medical Service and the examining boards in medical specialties, will continue its activities in the field of postwar graduate medical education and will prepare, as soon as possible, a list of available educational opportunities designed to meet the needs of returning medical officers.

"The hospitals that have already replied show an earnest desire to cooperate in this program in accordance with their ability to furnish adequate clinical and teaching facilities. Hospitals that have not yet answered are requested to return the questionnaire at the earliest opportunity so that the Council may proceed with the evaluation and listing of residency programs for the postwar period."

---

### Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, re-register with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of \$1.00. Initial applications may be made at any time, but existing permits must be renewed on or before July 1, annually.

Failure to re-register within the time allowed by law adds a penalty of 25 per cent to the annual tax, and in addition makes the physician liable to a fine not exceeding \$2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

Copies of the forms for re-registration have been mailed by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed. For several years the collectors sent a second notice about June 15 to physicians who had failed to re-register. This was discon-

tinued two years ago, and there will be no reminder this year.

Application for re-registration must be made on Form 678, signed by the physician applying, and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. Remittance accompanying the application may be in the form of cash, a postal money order or certified check. Personal checks, not certified, will be returned to the sender.

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Physicians who administer, dispense or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and re-register annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of \$1.00.

A physician in the armed forces need not re-register. If such a physician should receive an application form for re-registration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

A physician on entering service, who wishes to discontinue registration under the Harrison Narcotic Act, should return all unused order forms to the collector's office, and should dispose of all narcotics on hand, either by returning them to the wholesale concern from which purchased, if the packages are in unbroken form, or by transferring the narcotics to another physician, after having obtained permission for such transfer from the office of the Collector of Internal Revenue with whom he is registered.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

---

Arthur H. Compton, Sc. D., professor and chairman of the department of physics and dean of the division of physical sciences, University of Chicago, has been chosen chancellor of Washington University, St. Louis. Dr. Compton was professor of physics at Washington University from 1920 to 1923. He won the Nobel Prize for physics in 1927.





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# In Memoriam

**Braden Miller Alleman, MD., Cincinnati;** Eclectic Medical College, Cincinnati, 1929; aged 47; member of the Ohio State Medical Association and fellow of the American Medical Association; died May 10. Dr. Alleman practiced in Cincinnati for 16 years. He was a member and former secretary-treasurer of the staff of Bethesda Hospital. His widow, a daughter and four sisters survive.

**Alexander H. Beam, M.D., Cincinnati;** Medical College of Ohio, Cincinnati, 1890; aged 84; former member of the Ohio State Medical Association and the American Medical Association; died May 7. Dr. Beam practiced in Hillsboro for 27 years, during which time he founded a hospital there. He had lived in Cincinnati since his retirement from active practice in 1916. His widow survives.

**James Henry Boulware, M.D., Zanesville;** Leonard Medical School, Raleigh, N.C., 1911; aged 64; member of the Ohio State Medical Association and the American Medical Association; died April 30. Dr. Boulware had been located in Zanesville since 1931. He had previously practiced for 19 years in Fairmont, W.Va. A member of the staff of both Bethesda and Good Samaritan hospitals, Dr. Boulware also was active in community affairs. He was a trustee and treasurer of the St. Paul A.M.E., Church and had been treasurer of the Community Center. Surviving are his widow, two sisters and four brothers.

**Orlo Solomon Canright, M.D., Columbus;** Rush Medical College, Chicago, 1884; aged 88; former member of the Ohio State Medical Association and the American Medical Association; died May 1. Dr. Canright practiced medicine for nearly 60 years. He was located at Princeton, Minn., for three years; East Troy, Wis., for 28 years, and at Haskins, Wood County, Ohio, for 24 years. Dr. Canright retired about five years ago. He was president of the Wood County Medical Society in 1931-32, and active in civic affairs. Dr. Canright was a member of the Masonic Lodge, and the Modern Woodmen. His widow, two daughters and two sons survive.

**George Harold Carpenter, M.D., Marion;** Toledo Medical College, 1912; aged 62; member of the Ohio State Medical Association and the American Medical Association; died April 9. Dr. Carpenter first practiced in Morral, moving to Marion four years ago. He was a member of the Church of the Brethren. Surviving are his widow, two sons, two daughters, and three brothers.

**Joseph Wallace Chetwynd, M.D., East Liverpool;** Jefferson Medical College of Philadelphia,

## DIED WHILE IN MILITARY SERVICE

**Edward Joseph Humel, Jr., M.D., Cleveland;** Western Reserve University College of Medicine, 1941; aged 29; died April 1 in Paris, after a three-day illness from bulbar poliomyelitis. A first lieutenant in the Medical Corps of the Army of the United States, Dr. Humel reported for duty July 1, 1944 at Carlisle Barracks, Pa., upon the completion of a residency in medicine at University Hospitals, Cleveland. He had been overseas four months with a field hospital. Dr. Humel was a member of Alpha Omega Alpha. Surviving are his widow, a son and his father.

1907; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died May 2. Following graduation from medical school, Dr. Chetwynd was an assistant physician at the State Hospital for the Insane, Massillon, for four years. He practiced in East Liverpool for the past 30 years. Dr. Chetwynd was a former president and treasurer of the Phi Alpha Sigma medical fraternity and a member of the Presbyterian Church, Masonic Lodge and the Elks Lodge. His widow, a son, a sister and a brother survive.

**Etienne Pascal Crowe, M.D., Cleveland;** University of Wooster, Medical Department, Cleveland, 1889; aged 87; died May 6. Dr. Crowe was a medical examiner for the John Hancock Life Insurance Company for 30 years. He retired in 1920. Surviving are two brothers and a sister.

**Jesse Funderburg, M.D., Piqua;** Columbus Medical College, Columbus, 1886; aged 82; died April 14. Dr. Funderburg practiced in Piqua for nearly 50 years. He was a former coroner of Miami County. His widow survives.

**George Watson Jacoby, M.D., Ashland;** Ohio Medical University, Columbus, 1905; aged 64; died May 1. Dr. Jacoby practiced in Savannah and New London, before locating in Ashland in 1934. He was a charter member of the Elks Lodge of Ashland, and a member of Alpha Kappa Kappa. Surviving are his widow, two sons and a brother—Dr. M. W. Jacoby, Cleveland.

**Walter Harrison Loomis, M.D., Cleveland;** Cleveland-Pulte Medical College, 1904; aged 71; died April 17. Dr. Loomis practiced in Cleveland for nearly 40 years. He was a member and former deacon of the Euclid Avenue Baptist



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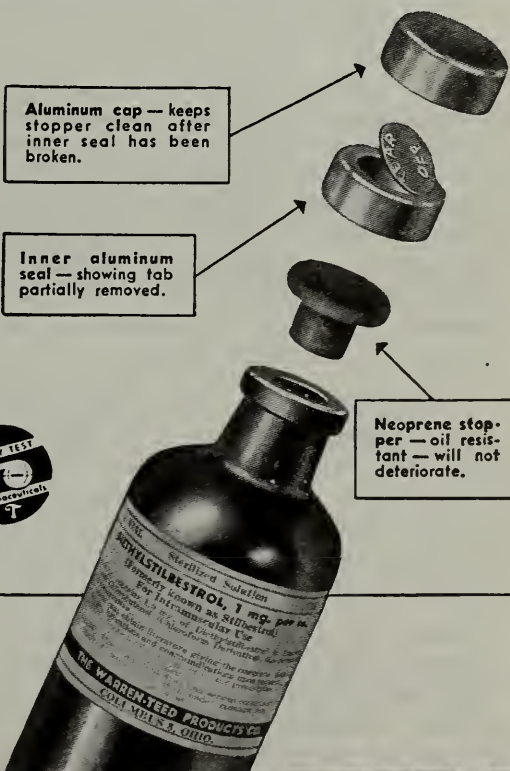
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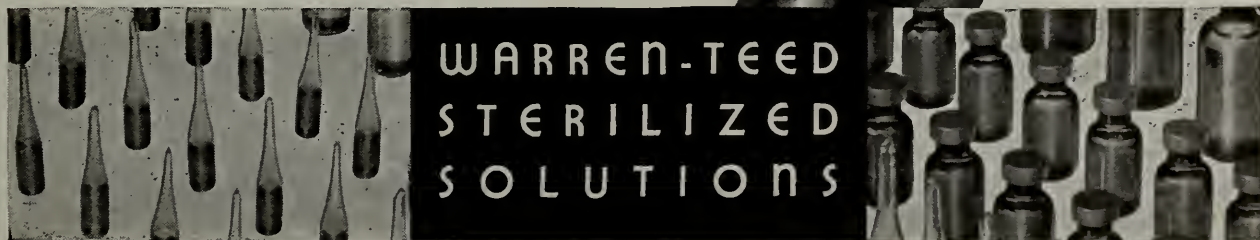
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Church. Surviving are his widow, a son, four daughters, a sister and a brother.

**Harry Hugo McClellan, M.D.,** Dayton; Vanderbilt University School of Medicine, Nashville, Tenn., 1912; aged 57; former member of the Ohio State Medical Association and the American Medical Association; member of the American Psychiatric Association; died May 1. A former superintendent of the Dayton State Hospital, Dr. McClellan was a psychiatrist in the U.S. Army during World War I, on duty at Macon, Ga. After the War, he returned to Dayton and after several years as assistant physician at the State Hospital, was appointed superintendent by Governor Vic Donahey in 1923, and served in that capacity for four years. Dr. McClellan wrote extensively on mental hygiene. He founded the Ohio Association for the Mentally Sick, for the purpose of improving conditions in state hospitals. Dr. McClellan was a member of the American Legion and the Masonic Order. Surviving are his widow, a daughter, a son and a sister.

**Robert Bogie Miller, M.D.,** Cincinnati; University of Cincinnati College of Medicine, 1941; aged 30; died May 4. Dr. Miller returned recently from Tucson, Ariz., where he was a member of the St. Mary's Hospital staff. He was a member of Sigma Alpha Epsilon and Nu Sigma Nu. His mother and a brother survive.

**Beriah Edwin Mossman, Jr., M.D.,** Youngstown; University of Pennsylvania School of Medicine, Philadelphia, 1900; aged 70; member of the Ohio State Medical Association and the American Medical Association; died May 3. Dr. Mossman had practiced in Youngstown for 27 years. He was a member of the Presbyterian Church and the Elks Lodge. Surviving are a daughter, a brother—Dr. Robert G. Mossman, Youngstown, and three sisters.

**Clarence S. Ordway, M.D.,** Toledo; Baltimore Medical College, 1902; aged 72; member of the Ohio State Medical Association and fellow of the American Medical Association; died April 27. Dr. Ordway practiced in Toledo for over 40 years, and in 1910 founded the East Side Hospital there.

**Walter V. Prentice, M.D.,** Toledo; Toledo Medical College, 1903; aged 69; member of the Ohio State Medical Association and the American Medical Association; died April 30. A staff member of the Toledo East Side Hospital, Dr. Prentice had been associated with the late Dr. Clarence S. Ordway for 35 years. He was a member of the Masonic Lodge and the Presbyterian Church. A son and a daughter survive.

**Allan Ramsey, M.D.,** Cincinnati; Medical College of Ohio, Cincinnati, 1896; aged 76; former

member of the Ohio State Medical Association and the American Medical Association; died April 10. Dr. Ramsey retired several years ago after having practiced in Cincinnati for more than 40 years. His brother survives.

**Fred Martin Rankin, M.D.,** Akron, Eclectic Medical College, Cincinnati, 1919; aged 55; member of the Ohio State Medical Association and fellow of the American Medical Association; died April 17. Dr. Rankin practiced in Akron for 25 years. He was a member of the Masonic Lodge, Delta Kappa Epsilon and Nu Sigma Nu. Surviving are his widow, two sons, two daughters and a sister.

**John Gottlieb Schwarz, M.D.,** Gallipolis; University of Cincinnati College of Medicine, 1912; aged 71; died April 19. Dr. Schwarz retired as superintendent of the Ohio Hospital for Epileptics in January, 1945, after having been on the staff for 31 years. He was made superintendent in 1943 after the death of Dr. G. G. Kineon. Dr. Schwarz was a member of the Lutheran Church and the Masonic Lodge. Surviving are his widow, a daughter, two sisters and a brother.

**Arnold Frederick Sydow, M.D.,** Cleveland; Ohio State University College of Medicine, 1926; aged 45; member of the Ohio State Medical Association and fellow of the American Medical Association; died April 28. Dr. Sydow was chief of the departments of plastic and children's surgery at St. Luke's Hospital and a member of the staff of City Hospital. He was active in the field of industrial medicine and had been one of the speakers in the Ohio State Medical Association Regional Postgraduate Lectures. Surviving are his widow, two daughters, his parents, two sisters and a brother.

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A \$5,000 grant has been given by Martha W. Hoster, Columbus, to St. Vincent's Hospital, New York, for the Laboratory of Cellular Physiology and Pathology to conduct studies in Hodgkin's disease with collaborators at New York University, Ohio State University and Walter Reed Hospital, Washington, D. C.

\* \* \*

Dr. Cecil Striker, Cincinnati, has been on a trip to Central America to study diabetes, under the sponsorship of the American Diabetes Association, of which he was the first president, and the U. S. Office of Inter-American Affairs, Division of Health and Sanitation.

\* \* \*

An application for a permit to hold an annual meeting of the House of Delegates of the American Medical Association in Chicago July 23 to 25 has been denied by the War Committee on Conventions. Further efforts will be made to have the meeting approved for a later date.



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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M. D., CINCINNATI)

### CLINTON

Dr. Robert Conard spoke on "The Anemias", at a meeting of the Clinton County Medical Society, May 2, at the General Denver Hotel, Wilmington. Dr. Carl A. Wilzbach, health commissioner of Cincinnati, was a visitor at the meeting.—R. W. DeCrow, M. D., secretary.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during May:

May 1—"The Anticoagulants and Thrombosis", Dr. Ovid O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison.

May 15—"The Medical, Psychiatric and Social Problems of War Neuroses", Lt. Col. Roy R. Grinker, M.C., U.S.A., Director of Professional Services and Psychiatry.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

### MIAMI

A comprehensive discussion of the proposed Dettmer Hospital was held at a meeting of the Miami County Medical Society, May 4, at the Coates Inn, West Milton. The meeting was in charge of Drs. I. C. Kiser, E. G. McCullough and E. G. Puterbaugh, who represent the Society on the Board of Trustees of the hospital.—G. A. Woodhouse, M. D., secretary.

### MONTGOMERY

Mack Sauer, Leesburg, country newspaper editor and humorist, spoke on "Early American History", at a meeting of the Montgomery County Medical Society, May 4, at Dayton. Members of the society were guests of the Fidelity Medical Supply Company at a buffet supper preceding the meeting.—C. J. Derby, M. D., president.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### MARION

Various local projects were discussed and approved at a meeting of the Marion Academy of Medicine, May 1, at the Marion City Hospital. Among them were a diagnostic survey for tuberculosis in the community sponsored by the Anti-Tuberculosis League, and a plan to furnish medical care for Jamaican laborers being imported to help the farmers of the county.—News clipping.

## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### LUCAS

The Academy of Medicine of Toledo presented the following programs during May:

May 4—General Academy Meeting. "The Problem of Tuberculosis Control", Dr. Howard Holmes.

May 11—Section of Pathology, Experimental Medicine and Bacteriology. "Hysterosalpingography as an Aid in Gynecologic Diagnosis", Dr. T. C. Kiess and Dr. M. E. Goodrich.

May 18—Medical Section. "Psychogenic Factors of Allergic Diseases", Dr. F. A. Rawling, section of allergy, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor.

May 25—Surgical Section. "Through the Needle", Dr. D. M. Katchka and Dr. John R. Phillips.—Bulletin.

## Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

### ASHTABULA

Dr. Thomas E. Jones, Cleveland, spoke on "Massive Intestinal Hemorrhage", at a meeting of the Ashtabula County Medical Society, April 10, at the Hotel Ashtabula, Ashtabula.—News clipping.

### CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during May:

May 2—Industrial Medicine and Orthopedic Section. "Dermatitis of the Hands and Feet", Dr. G. W. Binkley; "External Skeletal Fixation of Acute Fractures", Dr. H. J. Theisen.

May 18.—Annual Academy Meeting. "Experiences as Senior Consultant in Neurological Surgery for the European Theatre of Operations", Col. Loyal Davis, M.C., A.U.S. Editor of *Surgery, Gynecology and Obstetrics* since 1938, Col. Davis is professor of surgery at Northwestern University Medical School.—Bulletin.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

Dr. Harold N. Cole, Cleveland, gave an address on "Recent Advances in the Treatment of Syphilis", at a meeting of the Mahoning County Medical Society, May 15, at the Youngstown Club, Youngstown.—Bulletin.

### PORTAGE

Dr. Reginald Shipley, assistant professor of medicine, Western Reserve University School of



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Medicine, Cleveland, was guest speaker at a meeting of the Portage County Medical Society, May 3, at Robinson Memorial Hospital, Ravenna. His topic was: "Treatment of Obesity".—Emily Widdecombe, M. D., secretary.

#### SUMMIT

"The Chronic Fatigue States", was the subject of an address made by Dr. Charles L. Hartsock, Cleveland, at a meeting of the Summit County Medical Society, May 1, at the Nurses' Home, Akron City Hospital.—Bulletin.

#### PORTAGE

The latest treatment of endocrine problems in general practice was presented in a very interesting paper by Dr. Wm. M. Skipp, Youngstown, at a meeting of the Trumbull County Medical Society, May 17, at the Hotel Warner, Warren.

At a meeting on April 19, members of the society were privileged to hear Dr. Russell L. Haden, Cleveland, in a timely and educational address on "The Anemias".—C. Gray Caskey, M. D., secretary.

### Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

#### TUSCARAWAS

Dr. Oren A. Beatty, Mansfield, medical director of the Tuscarawas County Tuberculosis Sanatorium, was guest speaker at a meeting of the Tuscarawas County Medical Society, May 9, at the City Building, New Philadelphia. Dr. Beatty's topic was "Tuberculosis Control Program", and he also presented a number of interesting cases. His address was thoroughly enjoyed by the 11 members present.—C. J. Miller, M. D., secretary.

### Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

#### MUSKINGUM

At a meeting of the Muskingum County Academy of Medicine, May 2, at the University Club, Zanesville, Maj. T. C. Rizzo, chief of the orthopedic department, Fletcher General Hospital, Cambridge, gave an address on "Unusual Orthopedic Cases and Bone Grafts".—Beatrice T. Hagen, M. D., secretary.

### Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

#### SCIOTO

Members of the Hempstead Academy of Medicine enjoyed colored films on "Hysterectomy" and "Technique of Appendectomy by Inversion and Non-Ligation of Stump", at a meeting, April 19, at the Nurses' Home, Portsmouth General Hospital.—T. W. Frame, M. D., secretary.

### Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

#### FRANKLIN

The Columbus Academy of Medicine presented the following programs during May:

May 7—"Review of Transurethral Prostatic Resection", Dr. William N. Taylor, with discussion by Dr. Hugh Baldwin and Dr. Harley Bratton.

May 21—"Psychosomatic Medicine", Dr. Louis J. Karnosh, associate clinical professor of nervous diseases, Western Reserve University School of Medicine, Cleveland. The discussion was led by Dr. George T. Harding.—Bulletin.

### Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

#### LORAIN

At a meeting of the Lorain County Medical Society, May 8, at the Castle-on-the-Lake, Lorain, Dr. N. T. McDermott, Cleveland, spoke on "Recognition and Treatment of the Psychoneuroses". L. H. Trufant, M. D., secretary.

### WOMAN'S AUXILIARY NEWS

(By MRS. FRED W. BROSIUS, MIDDLETOWN  
Chairman, Publicity Committee)

#### Board of Directors Meeting Held In Columbus, April 18-19

The Board of Directors of the Woman's Auxiliary to the Ohio State Medical Association met at the Deshler-Wallick Hotel, Columbus, for a two-day conference, April 18 and 19. Mr. Paul E. Landis of the State Department of Education, spoke on the "Kellogg School Health Education Plan", at a luncheon session, April 18. Following the luncheon, Mrs. Roswell S. Fidler, Columbus, President of the Auxiliary, conducted a business meeting at which reports were given by the officers, district directors and chairmen of standing and special committees. On April 19 the business session was resumed with consideration of reports from the presidents of the county auxiliaries. The Board voted to have a conference of presidents and presidents-elect immediately preceding the Fall meeting of the Board.

#### RICHLAND

Mrs. Wilmot Pierce was named to succeed Mrs. Leopold Adams as president of the Woman's Auxiliary to the Richland County Medical Society, at a meeting held May 7, at the Women's Club, Mansfield. Other officers are: Mrs. Adams, president-elect; Mrs. Charles Brown, vice-president; Mrs. W. B. Wild, recording secretary; Mrs. Frank Maxwell, corresponding secretary and Mrs. W. W. Wygant, treasurer.

Hostesses at the meeting were Mrs. W. D. Abrams, Mrs. Charles Shafer, Mrs. H. F. Plaut



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and Mrs. L. D. Bonar. Mrs. J. L. Stevens led in prayer. Annual reports were given by the following committee chairmen: Mrs. Peirce, organization; Mrs. Brown, program; Mrs. L. B. McCullough, publicity; Mrs. C. H. Bell, in the absence of Mrs. F. M. Wadsworth, *Hygeia*; Mrs. Bell, social; Mrs. Stevens, legislature; Mrs. J. F. Morey, surgical dressings; Mrs. Wygant, War Bonds; Mrs. Wild, war participation; Mrs. John Clark, historian; and Mrs. C. R. Damron, bulletin.

#### BUTLER

The Woman's Auxiliary to the Butler County Medical Society met at the home of Mrs. C. I. Stafford, Oxford, April 24. Twenty members were present. The Auxiliary was honored by the presence of Mrs. R. S. Fidler, Columbus, State President; Mrs. David Heusinkveld, Cincinnati, State Secretary; and Mrs. Dale P. Osborn, Cincinnati, Past State President and President of the Hamilton County Auxiliary.

Mrs. Fidler discussed in an interesting manner the state organization. Mrs. Heusinkveld's topic was "Health Insurance; Compulsory or Voluntary". She outlined two plans of procedure, one as practiced on the West Coast and the other by the State of Michigan. A vast amount of information was imparted to the members by Mrs. Heusinkveld, on this timely subject. Mr. James Smith of Oxford, concert pianist demonstrated his virtuosity by playing a number of selections by the old masters, as well as his own compositions.

Mrs. Harry Burdsall, president, presided at the business session. Officers were elected for the ensuing year: Mrs. Fred Brosius, president; Mrs. C. J. Chamberlin, president-elect; Mrs. C. T. Atkinson, vice-president; Mrs. Kenneth Smith, recording secretary; Mrs. Melvin Fishman, corresponding secretary; Mrs. E. T. Storer, treasurer and Mrs. H. J. Baker, director for three years. The members will enjoy a picnic at the home of Mrs. H. J. Baker, Hamilton, in June.

#### FRANKLIN

Dr. George H. Ruggy, junior dean of the Ohio State University College of Medicine, spoke on "Expansion of the Ohio State Medical School and Postwar Plans", at the meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, in the Sessions Room of the Columbus Gallery of Fine Arts, Monday, April 16. Hostesses at the meeting were Mrs. Dan Sanor, chairman; Mrs. Morgan Davies, Mrs. Frank Harrah, Mrs. Howard Brundage, Mrs. Emery Hayhurst, Mrs. Joseph Berry, Mrs. Joseph Chronik, Mrs. A. H. Dunn, Mrs. A. F. McCoy, Mrs. Lawrence Wolfe, Mrs. Lawrence Turton, Mrs. L. M. Harris, Mrs. George T. Harding, Mrs. James Beer, Mrs. Ivor Clark, Mrs. Harry Minthorne, Mrs. Thomas Curran, Mrs. Hugh Dorr,

Mrs. J. A. Thone, Mrs. Peter Volpe, Mrs. George Woods, Mrs. H. C. Dorr and Mrs. James Carter.

#### SCIOTO

Maj. Louis A. Berndt, M.C., A.U.S., was guest speaker at a meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine, May 9, at the home of Mrs. Hubert Thurman, with 30 members present. Mrs. Clyde Fitch and Mrs. Frank Seidenburg conducted a memorial service with lighted candles for Mrs. Oscar Mickelthwaite, Mrs. D. A. Berndt and Mrs. William A. Quinn.

## Do You Know . . .

Dr. Edward J. McCormick, Toledo, was guest speaker at a meeting of the Allegheny County Medical Society at Pittsburgh, May 15. He will give the Commencement Address at the graduation exercises of the University of Georgia Medical School in Augusta, June 11.

\* \* \*

Otterbein College, Westerville, recently awarded the degree of doctor of humane letters to Dr. Mabel E. Gardner, Middletown physician and president of the Butler County Tuberculosis and Health Association.

\* \* \*

As part of its program of public health education during 1944, the National Society for the Prevention of Blindness sponsored 350 broadcasts by radio stations throughout the country, produced a documentary film, "Eyes For Tomorrow", which was shown approximately 600 times in more than 20 states; distributed more than a quarter of a million pamphlets, and utilized various other channels for reaching the public, such as newspapers, magazines and meetings.

\* \* \*

John M. Grece, for the past 15 years manager of the sales promotion department, has been elected assistant secretary of the Winthrop Chemical Company, Inc., New York and Rensselaer, N. Y. Sidney C. Mills, manager of the Chicago professional service office, has been promoted to regional manager of the mid-West professional service offices, and Arthur W. Jensen, with the company since 1934, has been named regional manager of the Eastern professional service offices.

\* \* \*

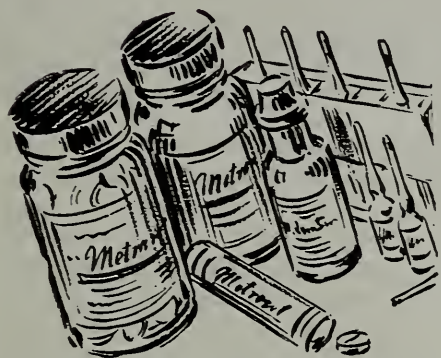
For the purpose of coordinating cancer research in the various university departments and to maintain contact and cooperation with cancer research in other universities, Ohio State University has created a new division of Cancer Research in the College of Medicine. It will be under the direction of Dr. Charles A. Doan, Dean of the College, with Dr. Herman A. Hoster, associate director, in charge of research.



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# WAR NOTES

Captioned "V-E Day Means Bigger Task for Army Medical Department", here is a news release from the Technical Information Division of the Office of the Surgeon General:

"The ending of hostilities in Europe means that the doctors, nurses, technicians and other personnel who comprise the Army Medical Department will now begin an even bigger job than they have been doing, which means there is no immediate prospect for the general release of personnel, Major General Norman T. Kirk, The Surgeon General, declared on V-E Day.

"The Medical Department, he pointed out, not only must continue to care for the sick and wounded but must make immediate preparations for the redeployment of troops to the Pacific or this country.

"One of the biggest tasks will be to give physical examinations to some 3,500,000 soldiers before they leave Europe. In addition, a goal of 90 days has been set in which to evacuate the sick and wounded from the European Theater to this country. Then there will be the final matter of redeploying the Medical Department personnel and equipment.

"Soldiers whose condition necessitates a medical discharge will be given further treatment and necessary examinations in the United States. All soldiers, prior to discharge from the service, will be screened for tuberculosis, syphilis and other diseases, and for possible strains and other physical defects. Thus hospitals here will

probably be operating at capacity with a critical need for medical personnel for many months to come.

"'Practically all officers and men in the Medical Department come in for the emergency', said the Surgeon General, 'and so far as we are concerned the emergency is far from being over.'"

Cleveland friends have had an enjoyable reunion recently with Maj. Ralph Hibbs, formerly of the Cleveland Clinic, who was at Bataan when it fell to the Japanese over three years ago. Dr. Hibbs was liberated from Camp Cabanatuan in February.

Lieut. Col. Richard L. Meiling, Columbus, was recently awarded the Legion of Merit "for services as air evacuation officer and executive officer, operations division, Office of the Air Surgeon, from Sept. 22, 1942, to July 11, 1944. Because of his thorough medical professional knowledge as well as his knowledge of air forces operations and organization, he was given the difficult and responsible assignment of preparing studies and plans for the organization of the first organized Air Evacuation Service. His enthusiasm, diplomacy and complete knowledge of his task enabled him to 'sell' this program to War Department chiefs of staff, theater commanders and our Allies. An ardent advocate of air evacuation, he has been ever active in the development of medical equipment peculiar to air

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evacuation. Today air evacuation squadrons are performing these duties in each theater of war. They have evacuated wounded from the South Pacific, Africa, Sicily, Italy and Normandy and in the Continental United States. Their contribution to the improvement of the morale of all personnel, as well as an aid to the tactical commander in the rapid evacuation of non-effectives, has proved to be of inestimable value in the prosecution of the war. His superior organizational ability and efficiency in the development of air evacuation of the Army Air Forces reflect the highest credit on himself and the armed forces of the United States." Dr. Meiling graduated from the Ludwig-Maximilians University Medical Faculty in 1937 and entered the service Oct. 7, 1940.

Since January, Col. Meiling has been based in London as chief of the Morale Division, United States Strategic Bombing Survey.

\* \* \*

The House of Representatives has passed H.R. 1812, authorizing the award of a certificate and a medal for faithful service to uncompensated personnel of the Selective Service System who have served for more than two years, including local board examining physicians and dentists and members of medical advisory boards. The medal will be known as the Selective Service Medal.

\* \* \*

News about Youngstown medical officers, from the *Bulletin of The Mahoning County Medical Society*: Capt. Densmore Thomas, "camping in a cocoanut grove, with plenty of banana trees around", somewhere in the Pacific area. . . . After landing in France the first week of the invasion, Capt. Howard E. Possner has travelled through various countries with elements of the First Army. . . . Capt. Oscar Axelson has been through a lot of rugged fighting in France, Belgium and Germany, with the medical detachment of an armored infantry regiment. . . . Obviously with the Third Army, Capt. Richard Goldcamp says "Daddy George" Patton is the best leader the Army has. . . . No evidence of food shortage in Saarlautern, the first large town Capt. Goldcamp's outfit took in Germany. Says he: "You should see those German houses. Each one a pillbox itself. And they are not new either. They were built years ago. Foundations really solid, wall of basements three or four feet thick and reinforced with steel girders or thick wooden beams. Quite a few have airtight air-conditioned rooms to be used in case of chemical warfare. Bunks are built-in in basement rooms and each room is equipped with an individual stove. Plenty of coal and coke stored. All sorts of canned food. The homes themselves are furnished beautifully. These people really lived well". . . . Lieut. Robert L. Piercy, at Madigan General Hospital, Tacoma, Wash. . . . Capt. Robert J. Heaver, with the University of Indiana unit, which has just opened its fourth general hospital in the

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E.T.O., two in England, one on Normandy, and now the first general hospital in Germany. . . Capt. F. L. Schellhase wages a bloody and bitter war each day with mosquitoes on an increasingly-abandoned island in the Pacific since the war moved into the Philippines and beyond. . . Lt. Col. W. D. McElroy and Maj. G. G. Nelson met at a two-day session of 800 officers at one of the general hospitals in the E.T.O. . . Maj. B. M. Bowman, busy as section chief taking care of convoys of injured somewhere in the E.T.O., possibly England. . . Maj. Walter J. Tims saw the Sunday afternoon promenade and that certain statue in Brussels. . . After nine months in Corsica, Capt. P. M. Kaufman has been in France since last September. Saw Drs. Nelson and McElroy on one of his trips to Naples. . . Capt. Clara Raven recently met Capt. Sydney Davidow in a nearby general hospital in France. . . Maj. Geo. L. Ambrecht, in Germany. . . Capt. B. M. Brandmiller, in a station hospital, has been "living in the jungles, without any evidence of civilization for 16 months".

\* \* \*

"Ohio should feel justly proud of its contribution to the Medical Department of the Army of the United States", writes Lt. Col. R. J. Borer, Toledo, with a general hospital in Belgium. There are many Ohio doctors, nurses and enlisted men in Col. Borer's unit, and he has met many more Ohioans in the course of his travels.

\* \* \*

Maj. G. D. Fridline, Ashland, taken prisoner by the Nazis on Dec. 21, has been liberated. Following his capture, he worked in a prisoner of war hospital.

\* \* \*

Maj. Edw. L. Montgomery, Circleville, who was a patient at Fletcher General Hospital after overseas service, is now on duty at the 1570th S.C.U., Med. Sec., Camp Breckenridge, Ky.

\* \* \*

Recently on duty in Washington, D.C., Maj. Frank Gollan, Cleveland, has gone overseas with the U.N.R.R.A.

\* \* \*

Lt. Salvatore Novello, U.S.P.H.S., Lima, is with the U.S. Coast Guard at Ketchikan, Alaska.

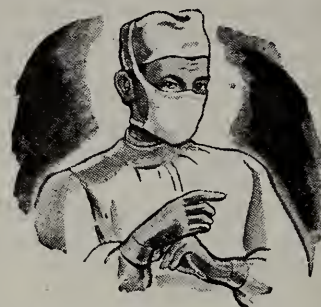
\* \* \*

Capt. Charles A. Bogue, Warren, is with a portable surgical unit in China.

\* \* \*

From the Philippines: Capt. A. P. D'Amore, Masury (Trumbull County), sends the good news that he is returning to the States. He has received *The Journal* regularly during the more than three years he has been overseas. . . . Maj. R. R. Pliskin, Akron, with a portable surgical hospital, has been "backing an active di-

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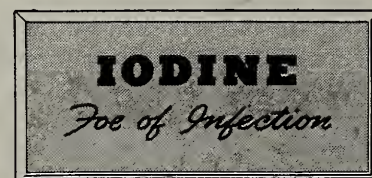
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\*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.



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vision in a heavy campaign". He says the "Island" seems like Ohio, for everywhere he goes he bumps into someone from home busily engaged in all types of medical activity. . . . On the surgical service of a station hospital, Maj. John C. Drake, Mt. Vernon, is in the same area as the 37th Division and has had quite a few patients from and near Columbus, and also cared for several liberated internees from Ohio. He saw Maj. Robert Eastman, his fellow-townsmen, in New Guinea, now reported to be back in the United States.

\* \* \*

Back after 18 months in the Pacific Ocean Area, Capt. A. F. Weiss, Marietta, has been enjoying a "delay en route" with his family. While overseas he was assigned to the Tripler General Hospital, on the surgical service.

\* \* \*

After about a year at Pearl Harbor, Comdr. W. E. Masters, Columbus, is now chief of medicine at the U.S. Naval Hospital, Quantico, Va.

\* \* \*

Since Lt. M. D. Shilling, Ashland, sailed from San Francisco last October, he has been to Milne Bay, New Guinea; Manus; Bougainville; back to Manus, Lingayen, Gulf, for the Luzon invasion; Leyte Gulf; Ulithi; Guam; Iwo Jima, where he stayed for two and a half weeks and watched a great deal of the fighting from the ship; Saipan; back to Guam and then to Tulagi. He can't tell where he has been since, because the rules say he has to stay 30 days back in reporting. However, Lt. Shilling did miss the Okinawa invasion.

\* \* \*

Capt. Bernard U. Howland, formerly of Portsmouth, is chief of urology with a general hospital in France.

\* \* \*

Capt. William J. Dalton says England is a lovely country, but he "can't wait to get back to the old Buckeye State and his home town, Cincinnati". He's in a general hospital unit. Maj. Samuel Goldblatt is another Cincinnati with a general hospital in England.

\* \* \*

Changes in location within the United States: Lt. Comdr. J. M. Ruegsegger, Cincinnati, Base Hosp., No. 4, A.B.A.T.U., Lido Beach, Long Island, N.Y.; Capt. Nathan R. Abrams, Cincinnati, 3868th S.U., Ashburn Gen. Hosp., McKinney, Texas; Capt. David L. Hirst, Miamisburg, Army Medical Center, Washington, D.C.; Capt. Cyril E. Myers, Akron, Lompec, Calif.; Maj. E. C. Pickard, Stow, 7th Service Command, Ft. Ord, Calif.; Lt. Geo. Y. Abe, Cincinnati, M.D.R.P., Tilton Gen. Hosp., Fort Dix, N.J.; Lt. Col. P. F. Briola, S.C.U. 1928, Camp Roberts, Calif.; Capt. L. W. Weller, Youngstown, 1882 S.U., Camp Maxey, Texas; Maj. Louis S. Zwick, Wads-

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Lt. C. B. Bowman, Cincinnati, Tinker Field, Okla.; Lt. Comdr. Victor F. Woldman, Naval Rec. Hosp., San Francisco, Calif.; Capt. Joseph B. Kupec, Youngstown, Med. Det., Wakeman Gen. Hosp., Camp Atterbury, Ind.; Capt. Samuel Tamarkin, Youngstown, 316th A.A.F.B.U., MacDill Field, Tampa, Fla.; Capt. Stanley E. Turel, Cleveland, Newton D. Baker Gen. Hosp., Martinsburg, W. Va.; Maj. Harold G. Beeson, Wooster, Fletcher Gen. Hosp., Cambridge; Capt. H. Glenn Overley, Loveland, Ft. Thomas, Ky.; Maj. Glenn H. Walker, Woodville, Colorado Springs, Colo.; Capt. Paul M. Corso, Salem, S.C.U. 1930, Presidio of San Francisco, San Francisco, Calif.; Major David P. Ward, Pemberville Hq., 143rd Med. Tng. Bn., Ft. Lewis, Wash.

\* \* \*

Recent arrivals in India: Maj. B. F. Wills, McArthur, with a general hospital, and Capt. Frank W. Anzinger, Springfield, in charge of the hospital at an air base. En route to his base, Capt. Anzinger had interesting stopovers at Cairo and Calcutta, and gets in his flying time now flying over the Hump. Ohioans at a nearby field are Capt. Nicholas G. Amato, Cincinnati, and Capt. E. D. Peelle, Wilmington.

\* \* \*

Maj. M. C. Archer, Medina, chief of X-ray at the Station Hospital, Camp Wolters, Texas, reports that Capt. George Emery, Ashland, is doing a very fine job there as assistant chief of the orthopedic department.

\* \* \*

Overseas 15 months, Capt. W. M. Wells, Columbus, is now in France, via Ireland and England. He has the dispensary for a replacement battalion. Capt. Wells recently met Capt. Vincent Black, Dayton, who is on the staff of a nearby station hospital.

\* \* \*

After 15 months continuous duty with the First Army, with no leaves or passes since June 24, 1944, Capt. Joseph Eiser, Toledo, now in Germany, wants to know: "How do I speed that trip home?" What's the answer to that \$64 question? He recently saw an O.S.U. '41, classmate, Maj. Gerhard Shearer, a recent arrival with the 15th Army.

\* \* \*

News about members of the Academy of Medicine of Cincinnati from the *Cincinnati Jour-*



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*nal of Medicine:* Lt. Warren L. Strohmenger, was in on the thick of the battle at Iwo Jima with the Marines. . . . And so was Lt. Comdr. Edward Friedman, aboard a ship which furnished the flag planted by the Marines atop Mt. Suribachi. . . . Maj. Herbert J. Brinker, Capt. Foster M. Williams and Capt. Irwin Kaplan, with a surgical team in Germany. . . . Capt. Wesley L. Furste, II, and Capt. George B. Haydon, surgeons with a medical unit of the Chinese Combat Command in South-Central China, participated in the Salween campaign. . . . Lt. Comdr. J. C. Danahy, returned recently from the Luzon campaign. . . . With the Seventh Army in Southern France (and presumably now in Germany), Maj. Thomas A. Weaver, Jr., comments, "There has been enough neuro-surgery here to last for several years at home". . . . Maj. T. Brent Wayman, at McCloskey General Hospital, Temple, Texas. . . . Capt. C. Richard Schroder, with that big Third Army in Germany. . . . Recently promoted, Col. Johnson McGuire is medical consultant for the Fifth Service Command, Ft. Hayes, Columbus.

\* \* \*

The envelope containing the 1945 membership card of Maj. A. L. Berndt, Portsmouth, was returned to the State Headquarters Office early in April marked "Missing". However, from a newspaper clipping we learn that Maj. Berndt is back home with his family, having been released from a German P. W. camp at Hammelburg on April 6. A regimental surgeon with the 28th Inf. Div., he was captured during Von Runstedt's breakthrough into Luxembourg on Dec. 16. On active duty for four years, Maj. Berndt went to England in the Spring of 1942 with a signal battalion and later transferred to the 28th, members of which wore the red Keystone shoulder patch. The Germans nicknamed it the "Bloody Buckets" Division.

\* \* \*

On duty with the Fleet: Comdr. H. P. Lyle, Norwood; Lt. (j.g.) Eli J. Weller, Cincinnati; Lt. Comdr. F. S. Hosking, Cleveland; Lt. (j.g.) S. E. Burkhart, Cleveland; Lt. Ralph M. Bone, Cleveland; Lt. M. P. Thomas, East Cleveland.

\* \* \*

The Bronze Star Medal has been awarded to the following Cleveland medical officers: Col. Roger O. Egeberg, Col. Neville H. McNerney, Capt. Frank R. Hanrahan, Capt. Edwin S. Kessler, and Capt. Frank O. Albl.

Now in the Philippines, Col. Egeberg was cited for "untiring efforts and the highest devotion to duty in the training of troops in the Milne Bay, New Guinea area from Oct. 28, 1942, to Jan. 31, 1943, in mosquito control and

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discipline, which reduced the malarial rate in a highly malarious area".

Col. McNerney has been serving as commanding officer of a hospital center in England, and also acts as inspector for a group of Army hospitals. Capt. Hanrahan and Capt. Kessler, Western Reserve graduates in 1942, served with the 95th Inf. Division in Germany. On duty at a battalion aid station, they were decorated for "heroic achievement in connection with military operations against the enemy in their Division's historic reduction of Metz".

Another Clevelander to be decorated is Maj. Harold R. Rossmiller, who wears the Legion of Merit.

\* \* \*

The Soldier's Medal for heroism has been awarded Capt. Edward T. Keating, Hamilton, for his actions on Christmas Day in helping save the lives of three American air-men. The medal was presented Capt. Keating by Major General Samuel E. Anderson, Commanding General of the Ninth Bombardment Division.

The incident occurred Christmas morning when a B-26 bomb-laden Marauder crashed in flames at this Ninth Air Force Base in France shortly after take-off. With other officers and soldiers in the vicinity, Capt. Keating rushed to the site of the accident and immediately undertook the hazardous task of rescuing the trapped crew. Ammunition was exploding continuously in the blaze and the detonation of the bombs seemed likely to occur at any moment, but the men persisted in their rescue work. Although one of the bombs became red hot, and the heat from the fire was intense, the men dragged three members of the crew to safety. Capt. Keating is flight surgeon for one of the squadrons of the 386th Bombardment Group.

\* \* \*

Maj. M. S. Udelf, Cleveland, with a general hospital, somewhere overseas, reports the recent promotion of the chief of the G-I Section, Maj. A. Krivonos, Cleveland Heights, and the transfer to the surgical staff of another Cleveland, Capt. Robert Sating.

\* \* \*

News about Clevelanders on the war fronts, courtesy of *The Bulletin of the Academy of Medicine of Cleveland*: Capt. Julius W. Pastor, in China with the Y-force since March, 1944. . . . Lt. Comdr. Russell G. Witwer, on a carrier torpedoed off Iwo Jima, rescued after several hours in the water, by a destroyer escort, on which he worked all night with wounded men. On the following day he landed at Iwo Jima and was sent to Saipan and Pearl Harbor with wounded Marines. Thence home on leave for a well-earned reunion with his family. . . . Also home, Maj. Jack Meltzer, after 37 months

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### Highlights for July

- \* THE EFFECT ON THE BLOOD PRESSURE OF NORMAL PERSONS AND HYPERTENSIVE PATIENTS OF GLYCERYL TRINITRATE, SODIUM NITRITE, ERYTHROL TETRANITRATE AND MANNITOL HEXANITRATE—*American Heart Journal*
- \* THE TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS WITH PENICILLIN—*Journal of the American Medical Association*
- \* THE EFFECT OF PENICILLIN ON RHEUMATOID ARTHRITIS—*Proceedings of the Staff Meeting of the Mayo Clinic*
- \* PROBLEMS OF TREATMENT OF TROPICAL DISEASES IN RETURNING MILITARY PERSONNEL—*New York State Journal of Medicine*



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in New Guinea and Leyte. . . . After 23 months overseas, Capt. Chester Lulenski returned home on convalescent leave. He was a paratroop surgeon with the 82nd Airborne Division in Normandy, Holland, the Battle of the Bulge and Germany. Prior to that time he was with the same unit in Sicily and at Salerno. His was in an airborne medical company which landed in gliders during military operations.

Maj. W. M. Barth, in a South Coast port in England receiving casualties from hospital ships, had a week's temporary duty in London, where he saw a few fine shows and had good food. . . . Capt. M. E. Crawford, chief of shock and emergency ward on 12-hour shifts, somewhere in France, recently spent some time with Paul Mielcarek and Jim Gavin. . . . Capt. M. J. Krisko, also in France. . . . Capt. Joe M. Rossen, retired to inactive status and re-entering practice at old stand in Lakewood. . . . Lt. Comdr. Charles F. Ward, Purdue Naval Training Station, Lafayette, Indiana, expecting to be transferred abroad again soon, had an article on "Rupture of Rectus Muscle" in *Naval Medical Bulletin*. Capt. Jacob W. Werle, doing brain surgery, says Luxembourg is more like U.S.A. than England.

Maj. Fred R. Kelly, with an evacuation hospital in England in February, boosts "our wonderful ally, Penicillin". . . . Capt. Gardner G. Bassett, in Belgium. . . . Lt. (j.g.) Charles Larsen, Jr., beach battalion medical officer on a ship. . . . Lt. Col. Arthur D. Nichol, consultant for the Twelfth Hospital Center and chief of the medical service for a general hospital. . . . Lt. Comdr. Robert A. Reading, home on leave recently. . . . Lt. Col. Walter M. Solomon, recently promoted, is assistant chief of medicine with the Fourth General Hospital in New Guinea, of which Lt. Col. Donald M. Glover is the C.O. . . . Lt. (j.g.) P. J. Robeck, at the U.S. Naval Hospital, Corvallis, Oreg. . . . Capt. Harry H. Robinson, cited for meritorious service in connection with military operations against the enemy on Kwajalein at Eniwetok, Feb. 1 to July 1, 1944. . . . Lt. E. D. Richards, wounded in the thigh by a sniper bullet at Iwo Jima, recently at the U.S. Receiving Hospital, San Francisco, making a good recovery and expecting to be transferred to Great Lakes. . . . Lt. Ralph S. Rosewater, reported back to Wm. Beaumont Hospital, El Paso, Texas, after a 30-day medical leave.

\* \* \*

After spending two and one-half years with the First Cavalry Division, Maj. William L. Porter, Cincinnati, in the middle of the (censored) was transferred to 112th Cavalry Regiment as regimental surgeon. Shortly after the close of the (censored), his unit moved north again to its present location. It arrived there

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the latter part of January and has been in combat ever since. After two years overseas, "Ohio and Heaven seem one and the same. I am looking forward to the day when I can be there once again", says Maj. Porter. (The censor removed all clues as to his whereabouts, but we'd guess the Philippines.)

\* \* \*

From the Public Relations Office of the First Allied Airborne Army, we learn that Capt. L. D. Bonar, Mansfield, has been presented with his fifth bronze battle star, for service in five major campaigns in the E.T.O. Capt. Bonar's unit, the 436th Troop Carrier Group, performed troop carrier operations in the areas of Northern France, Southern France, Normandy, Rome-Arno and Germany. The group was previously awarded the Presidential Unit Citation for its successful fulfillment of airborne drop operations on D-Day in Normandy, and has since carried out thousands of resupply and air evacuation missions between combat sorties. Capt. Bonar entered the service in June, 1942, and has been serving overseas since early 1944 as a flight surgeon.

\* \* \*

Capt. Geo. B. Watson, Columbus, is enjoying the change from a general hospital staff in Assam to the job of battalion surgeon for a mobile Qm. Unit in that area. He travels by air and vehicle, checking on six dispensaries.

\* \* \*

A member of the U.S. Air Corps in World War I and an officer in the Medical Corps in World War II, Lt. Col. Hobart L. Mikesell, who recently received an honorable discharge from the Army of the United States, plans to resume the general practice of medicine in West Liberty. Activated with the 37th Division in the Fall of 1940, Dr. Mikesell went overseas in 1942, and was stationed at Guadalcanal, New Zealand and other posts. Returning to this country last year, he took a postgraduate course in surgery at the Mayo Clinic, Rochester, Minn., and then was assigned to Hollywood, Calif., to take a directional part in the filming of a special Army medical film at the Warner Bros. studio.

Some additional changes of location within the United States: Capt. Nelson A. Brandeberry, Springfield, Regional Sta. Hosp., Kirtland Field, Albuquerque, New Mexico; Maj. Robert E. Wolfe, Uhrichsville, Hq., A.G.F.R.D. No. 1, Ft. Geo. G. Meade, Md.; Lt. Comdr. R. G. Witwer, Cleveland, reassigned after the sinking of his carrier, to U.S. Naval Air Station, Melbourne, Fla.; Maj. Richard T. Sauer, Dayton, 1550 S.U. Med. Sec., Ft. Knox, Ky.; Capt. M. H. Rosenblum, Steubenville, Wakeman Gen. Hosp., Camp Atterbury, Ind.; Maj. Lewis K. Reed, Youngstown, Ashford Gen. Hosp., White Sulphur

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\* \* \*

Lt. Col. Harrison Evans, Columbus, is chief of the neuro-psychiatric section of a general hospital in New Guinea.

\* \* \*

Dr. John H. Nichols, Director of Physical Education, Oberlin College, Oberlin, has been in France and Belgium as a civilian consultant with the Special Services Division of the Army. He heads up an athletic clinic to train officers in an all-around sports program for the troops still in the E.T.O.

\* \* \*

Recently returned from England, Capt. H. G. Overley, Loveland, is at present "personal physician", in the Convalescent Services Division, A.A.F. Convalescent Hospital, Ft. Thomas, Ky.

\* \* \*

"Things have quieted down" where Capt. John Q. Brown is located with a station hospital in the Philippines, but while he was busy, he worked "28 hours out of 24".

\* \* \*

Maj. William A. Davin has returned to civilian practice in Hamilton. Entering the service in August, 1942, he was stationed at Rapid City Air Base, South Dakota, for 22 months, as base surgeon, and then at Ft. Devens, Mass., as assistant chief medical officer and chief of the cardiovascular section.

\* \* \*

Maj. W. A. Baird, C.O. of a portable surgical hospital, writes this from the Philippines: "Have very little about which to complain and have been extremely lucky. Ohio's own 37th Division has the reputation here as about the fightingest outfit in these islands. Wish I could support them some time. Expected to be rotated in '45, but recently received bad news requiring 30 months service for eligibility, and I have only 20."

\* \* \*

S. 939 and H.R. 3070, respectively, have passed the Senate and the House of Representatives, authorizing the Secretary of War, for the duration of the wars in which the United States

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Lt. (j.g.) Howard M. Schriver, Cincinnati, is medical officer for a squadron of mine sweepers, somewhere away out there in the Southwest Pacific.

### Where Medical Officers Plan To Locate After War Shown in Study

Forty-seven per cent, or 9,649 medical officers, indicated that they wished to return to practice in their former communities after the war, Lieut. Col. Harold C. Lueth, Medical Corps, Army of the United States, reports in the April 21 issue of *The Journal of the American Medical Association* in the presentation of an analysis of answers to questionnaires sent to 21,029 medical officers in the armed forces. More than 21 per cent, or 4,310 medical officers, signified that they did not intend to re-engage in practice in their former communities.

These findings, Colonel Lueth points out, are important because of the concern which has been expressed about the number of men who will seek licenses to practice medicine after the war. The study was made by the Committee on Post-war Medical Service of the American Medical Association.

The 21,029 questionnaires studied represent about 35 per cent of all medical officers on duty. These were divided into six groups on the basis of date of graduation from medical school. There were about an equal number of men who came under the first five groups, but group 6, those who had graduated before 1920, formed a very small number.

An analysis was made of the medical officers as to licensure by graduation groups and by length of service in the armed forces. Ninety-two per cent of all officers, or 19,391, had licenses to practice medicine, and 1,590 did not possess a license to practice. Only 48 men failed to answer this part of the questionnaires. There were 331 graduated between 1938-1940 who did not have a license, or 21 per cent of all the unlicensed medical officers studied. Most of this group had served for some time; 85 per cent had been in service for two or more years.

Colonel Lueth explains that nearly all the men in this group left internships and residencies and went directly to the armed services. It is believed that many of the men in this group will seek a license to practice medicine soon after release from military service so as to enable them to engage in civilian medical practice. It should be mentioned that a certain number of men

without licenses will probably remain in governmental service; consequently they will not need licenses to practice. Also there were a small number of officers of the regular Medical Corps in these groups, who very likely will not seek licenses in the future. . . ."

There were only 69 medical officers who had graduated prior to 1937 that did not have licenses.

Less than half of the 4,310 medical officers who signified that they did not intend to re-engage in practice in their former communities gave a definite locality in which they would like to practice after the war. The rest merely left the question as to location of practice unanswered.

In analyzing these figures, Colonel Lueth says, "The large number of medical officers who indicated that they would establish a civilian practice of medicine in a community other than the one they left to enter military service may at first seem startling. It should be remembered, however, that under normal conditions there are a certain number of civilian physicians who move from one community to another. . . ."

"There were 8,379 medical officers who gave no answer to where they would like to practice. More than four-fifths of them were graduates of groups 1 and 2 (graduated between 1938-1943) and consequently had probably never had an established practice of medicine."

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\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
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# The Physician's Bookshelf

**Yellow Magic.** The Story of Penicillin, by J. D. Ratcliff, (\$2.00. *Random House, New York City*) tells in a comprehensive way how this wonder drug was discovered and developed. Americans should not forget that it was the drug manufacturers and the American Chemical Industry who responded and produced with extraordinary and untried methods almost fantastic amounts of this precious material to save our wounded and infected. Certainly it is a tribute to capitalism. The editor of *Science Year Book* makes this story most interesting.

**The Technique of Bandaging and Splinting,** Including Section on Slings and Adhesive Plaster Strapping by Arthur M. Tunick, M.D. (\$3.00. *Duell, Sloan & Pearce, Inc., New York City*) is a complete book on the subject in simple language and clearly illustrated with 250 drawings.

**The Examination of Reflexes.** A Simplification, by Robert Wartenberg, M.D., with Foreword by Foster Kennedy, M.D. (\$2.50. *The Year Book Publishers, Inc., Chicago, Ill.*) analyzes the multitude of names and claims. This is most helpful of the testing of reflexes and their proper evaluation undoubtedly constitutes one of the important parts of the examination of a patient.

**Uncle Sam Convalescing,** by H. Ameroy Hartwell, M.D. (\$2.00. *Bruce Humphries, Inc., Boston, Mass.*) is a glimpse into Uncle Sam's hospital record from 1933-1940 written in a medico-analytical style by a well known doctor-author. It is an interesting document in experimental therapy. It is a book you will enjoy.

**Primate Malaria.** By S. D. Aberle, M.D., (*Issued by the Office of Medical Information, National Research Council Div. of Medical Sciences*) is designed to give research workers a view of the contributions on the subject and to provide them with a source of ready reference.

**Proceedings of the Twentieth Annual Meeting of the Ohio Student Health Association,** by G. T. Blydenburg, M.D., Delaware, Ohio, Secretary, presents a lively discussion of such pressing problems as mass X-ray Programs, Endocrine Problems of the College-Age Female, Medical Problems of Veteran-Students.

**Proceedings of the Rudolf Virchow Medical Society,** (\$2.00. *Brooklyn Medical Press, Inc., New York City*) reports the 1944 meetings of this 94-year old society.

**The Attendant's Guide,** by Edith M. Stern, (\$0.50; less in quantities. *The Commonwealth Fund, New York City*) is a manual for the employees of the mental hospital. A timely volume to meet a need since nothing like it exists and hundreds of employees need it for orientation.

**Electroencephalograms of Normal Children,** by Charles E. Henry, (*Monograph of the Society for Research in Child Development. Vol. IX, No. 3, Serial 39*) aims at the development of standards.

**The Doctor's Job,** by Carl A. L. Binger, M.D., (\$3.00. *W. W. Norton & Co., New York City*) is the winner of the 1945 Norton Medical Award. The publishers reported a second printing of 10,000 copies just a few days after the book was released. The New York City book trade took 5,000 copies of the first run in four days. So by the yardstick of the book trade, the book is a great success.

The book explains for the layman how the modern physician can aid his patients with the help of the advances made in psychiatric, psychoanalysis, bacteriology, and pathology. The author discussed the problems of socialized medicine in terms of well being. It is all done, however, with the sureness of a professor in a great metropolitan university. New York City has come to be a foreign country in medical economics as well as socially. In the great hinterland things are not as they are imagined in "radio city".

**Your Hair and its Care,** by O. L. Levin M.D., and Howard T. Behrman, M.D., (\$2.00 *Emerson Books, Inc., New York City*) is an important book. Important for the reason that no branch of medicine has made more rapid progress in the last ten years than the field of hair and care and diseases of the hair. A worthwhile book full of important information apparently written for the layman to put us on our toes.

**Buckeye Tales,** by Homer L. Royer and Ollie E. Fink (\$1.50. *Lyons & Carnahan, Chicago*), gives the historical lore of our great state in terms of conservation misuse and conservation of the natural resources of Ohio. It is a splendid book to give the small child and many of us older people have not learned its lessons.

**Penicillin Therapy Including Tyrothricin and Other Antibiotic Therapy,** by John A. Kolmer, M.D., (\$5.00. *D. Appleton-Century Co., Inc., New York City*) is an excellent critical review of the literature to date by this well-known authority on medicine and laboratory procedures. One of the books that every physician should read and that right away.

**Contagious Diseases.** A guide for Parents, by W. W. Bauer, M.D., (\$2.50. 2nd Ed. *Alfred A. Knopf, Inc., New York City*) is just what its title claims. The reception of the previous edition speaks for the acceptance of this one. It is a book that you can well recommend to parents.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

July, 1945

No. 7

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## A Low Back Pain Routine

W. RICHARD HOCHWALT, M.D., A.E. CULMER, JR., M.D., and SION C. ROGERS, M.D.

ONE of the most common and mystifying conditions met in both military and civilian practice is low back pain. This complaint is common in all types of practice. It must be approached by both general practitioners and specialists in most fields of surgery and medicine. Many physicians are inclined to consider that little can be found and that detailed questioning and exhaustive physical examination do not present findings worthy of the expended time and energy. They are too often content with observing the motions of the back of a patient, who has simply removed his coat, and palpating the back through the shirt and underclothes. These patients are frequently dismissed with a few pills and told that the condition will correct itself within a few days. Some patients volunteer the information that they suggested an X-ray but were told that it would be of little value.

It is frequently impossible to cure patients of this complaint if they are psychoneurotics, malingerers, or if there is litigation pending. Patients frequently use this complaint as an escape from unpleasant duties or situations. A careful, thorough history and physical examination will often be valuable in allaying this complaint, especially in the psychoneurotic.

It is the purpose of this paper to present a workable approach to this problem.

### HISTORY TAKING

In taking the history it is helpful to think of low back pain as falling into one of two groups: First, pain due to some intrinsic pathology in the back; second, extrinsic, symptomatic back pain due to pathology in another system, such as the genito-urinary or gastro-intestinal sys-

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tems. A detailed history will usually give an excellent clue as to which system is involved.

The first consideration should be the type of onset of the pain. Was it insidious, without definite trauma as in postural or occupational strains, inflammatory conditions, or structural weaknesses, or was it sudden in onset, as in a definite injury? If due to trauma, what was the mechanism of injury? It is important to determine the exact mode of injury, that is, in what position it was incurred. Was the patient attempting to lift a weight with his back flexed? This is a common injury to the lower lumbar

region, whether lumbar sprain, or ruptured intervertebral disc. Rotary force is frequently transmitted through the lumbar spine to the sacro-iliac joints resulting in sacro-iliac sprain.

Occasionally cases are seen in which severe pain followed relatively minor trauma. In most of these cases there is a predisposing factor, such as poor posture, structural abnormalities, or chronic inflammatory conditions.

As a natural sequence to the onset of the pain, careful inquiry into its location and character is important. Is the pain localized in the low back? Does it radiate? If radiation is into the lower extremities, what course does it follow? In lesions of the intervertebral discs the usual history is that of more or less localized pain in the low back followed later by radiation into the lower extremity. Is it constant or intermittent, acute, sharp, or dull and aching? Is it aggravated by coughing, sneezing, or bowel movement as is sometimes seen in lesions of the intervertebral discs?

There are four common types of pain, the consideration of which may facilitate diagnosis. For convenience they can be classified as, afternoon, forenoon, nocturnal or incessant pain.

**Afternoon**, or static pain, that type which is produced or aggravated by activity, and which improves with rest. This is characteristic of postural and occupational strains, and structural defects which produce a mechanically unstable back, such as spondylolysis, spondylolisthesis, asymmetry of the articular facets, structural scoliosis, and spina bifida if there is involvement of the ligamentous attachments.

**Forenoon**, or morning pain, that which follows rest. This occurs frequently in cases of fibrositis, myositis, and mild chronic arthritis—the group of cases which can be classed as mild chronic inflammatory conditions.

**Nocturnal pain**, is frequently present in neurological conditions, such as, herniated intervertebral discs and spinal cord tumors. Severe arthritis and severe infectious processes may also cause this type of pain.

**Incessant**, or unremitting pain, that pain which is produced by tumors and severe infections, such as tuberculosis and osteomyelitis. Malingerers and psychoneurotics often state that their pain is continuous in an effort to emphasize their complaint.

Any interrogation with regard to history should include systemic history and past history, noting especially previous treatment and response. This will aid in determining a plan of treatment and will possibly indicate the causative factor.

#### EXAMINATION

A complete physical examination is essential, however we will limit our remarks to the routine examination of the low back. No examina-

tion can be satisfactory unless the patient is completely disrobed, including removal of the shoes and socks. It is frequently helpful, in evaluating the amount of pain a patient has, to watch him undress. Quite often a patient will stand on one foot to remove the other shoe without apparent difficulty when not under direct examination, but when asked to bend forward states that he can not.

Examination should be carried out in a definite, organized manner. Our routine is as follows:

**Inspection:** This will reveal any abnormalities in posture or gait, such as round shoulders, scoliosis, kyphosis, a list, increase or decrease in the normal lumbar lordosis, protruding abdomen, pelvic tilt, as well as abnormalities of the extremities such as bow-legs, knock-knees, flat feet, or inequality in length. The presence or absence of muscle spasm or muscle atrophy should be noted. A patient with severe sciatic pain will frequently stand with the affected leg flexed slightly at the hip and knee with the weight on the ball of the foot in an effort to relax the hamstrings.

**Motions:** Careful examination of the mobility of the spine should be carried out with the patient standing, sitting, and reclining supine and prone. In an acutely painful back all motions are markedly limited both actively and passively. In this acute phase complete examination may be impossible and, therefore, an accurate diagnosis can not be made on the initial examination. These cases should be re-examined when the acuteness subsides. Forward and backward bending, lateral bending to each side, and rotation of the spine are observed in all three positions. Careful analysis of these motions aids in making a diagnosis. See Table No. 1.

It should be remembered that forward flexion in the standing position is analogous to straight leg raising in the supine position, the former being carried out actively and the latter passively by the examiner. Also, forward flexion in the sitting position is analogous to passive flexion in the supine position with the knees flexed. Malingering or exaggeration is sometimes revealed by this cross-checking of the motions, as for example, a patient who can not forward flex while standing but has normal straight leg raising.

**Palpation:** This should be systematic and with a knowledge of the anatomic structures being palpated. Tenderness due to a specific lesion is usually well localized. However, in cases of fibrositis or myo-fibrositis, the tenderness is apt to be diffuse. Palpation and percussion should be carried out in all the three positions mentioned above. The abnormalities noted by inspection should be verified by palpation. A mild or moderate degree of gibbus may be overlooked during inspection but is readily picked



TABLE No. 1  
Analysis of the Motions of the Spine in Low Back Pain

| MOTIONS                                                                     | LUMBAR SPINE LESIONS                                                                                                         | SACRO-ILIAC LESIONS                                                                                              | RUPTURED DISCS                                                                                                                                                                                |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Forward flexion. Standing.                                                  | Motion takes place in dorsal spine and hip joints. Sacrospinalis musculature remains taut preventing motion in lumbar spine. | Flexion of lumbar spine to limit of elasticity, stops as soon as pelvis tilts forward rendering hamstrings taut. | Flat lumbar spine, usually with a list away from affected side. Motions same as in lumbar spine pathology.                                                                                    |
| Forward flexion. Sitting.                                                   | Same as in standing position.                                                                                                | Free flexion because of relaxed hamstrings.                                                                      | Same as in standing position.                                                                                                                                                                 |
| Reclining (motion performed passively by examiner).**                       | Limited because leverage is transmitted to lumbar spine and is the same as flexion in sitting position.                      | Can be performed freely because hamstrings are relaxed and pelvis moves as a whole.                              | Limited as in lumbar spine pathology.                                                                                                                                                         |
| Lateral bending.                                                            | Not so instructive usually slightly limited in both directions.                                                              | Usually limited toward the affected side.                                                                        | Away from affected side gives relief. Bending toward affected side often increases pain and if this position is maintained may increase radicular pain and reproduce the pattern of leg pain. |
| Hyperextension.                                                             | May cause increased pain in facet lesions and decreased pain in strain of posterior ligaments due to relaxation.             | May perform this motion without increasing pain.                                                                 | Limited, often increases pain.                                                                                                                                                                |
| Straight leg raising (corresponds to forward flexion in standing position). | Bilaterally, moderately, limited. Hamstrings under tension.                                                                  | Markedly limited on affected side.                                                                               | Marked limited on affected side produces increase in radicular pain.                                                                                                                          |

\*\*Passive flexion (with knees flexed) corresponds to forward flexion in sitting position.

up by careful palpation. This is seen in compression fractures and destructive lesions of the vertebral bodies and represents the tilted spinous process of the vertebra above the diseased one. In spondylolisthesis, the spinous process of the involved vertebra is prominent, since the pedicular lesion allows the body to slip forward and the cephalad portion of the spine follows.

Tenderness in the costo-vertebral angles may indicate possible genito-urinary pathology or injury to the first lumbar transverse process. Tenderness over the tips of the spinous processes may suggest fracture or disease of the vertebral body or of the spinous process itself. Interspinous tenderness is frequently found with sprains involving the interspinous ligaments. Palpation of the ilio-lumbar angle may reveal pathology in any of the following structures: the fifth lumbar transverse process and articular facets, the ilio-lumbar ligaments, and the erector spinae muscles. In intervertebral disc lesions, deep palpation and percussion over the suspected level just lateral to the spinous process may produce typical radiation of pain.

Tenderness over the dorsum of the sacrum is frequently found and is usually associated with postural or muscular strains, often with exaggerated lordosis, but may be due to muscle spasm caused by other lesions. Localized tenderness between the superior and inferior posterior iliac spines is most frequently present in sacro-iliac lesions. Sacro-sciatic notch tenderness may indicate sacro-iliac disease but is frequently seen in other types of lesions causing sciatic radiation of pain.

Palpation should also include a rectal examination in all male patients and a vaginal examination in female patients when indicated. Prostatic involvement is a frequent cause of low back pain.

#### SPECIAL TESTS

There have been many tests described for the differential diagnosis of low back conditions. The ones that we have found to be of the most aid are as follows:

**Straight Leg Raising:** With the patient supine on a firm table and with the knee in complete extension, the lower extremity is flexed at the hip. In a normal patient this should be possible to 70 to 90 degrees without pain. (This corresponds to forward flexion in the standing position, except that it is carried out passively by the examiner.)

**Lasegue's Sign:** This is performed exactly the same as straight leg raising to the point at which pain occurs. At this point the foot is acutely dorsi-flexed, thus stretching the sciatic nerve. This test is positive in lesions causing sciatic radiation of pain.

**Patrick's (fabere) Test:** With the patient supine, the thigh and knee are flexed, and the external malleolus is placed over the patella of the opposite leg. The knee is then depressed. If there is pathology in the hip joint it is impossible to carry out this test because of pain and muscle spasm.

**Gaenslin's Test:** With the patient supine, the hip and knee on the unaffected side are fully flexed to flatten the lumbar spine and fix the pelvis. The extremity on the affected side is

hyperextended over the side of the table. This produces a shearing force on the sacro-iliac joint and if pathology is present will be painful.

**Ely's or Nachlas' Test:** With the patient prone, flexion of the leg on the thigh tightens the anterior thigh muscles and fascia, rotates the pelvis forward, and causes pain in the corresponding sacro-iliac joint (if pathology is present). When both legs are flexed at the same time the pelvis rotates as a whole, causing pain in the lumbo-sacral area, if pathology is present.

**Soto-Hall Test:** With the patient supine, forcible flexion of the cervical spine produces tension

be accomplished by measuring the distance between the anterior superior iliac spines and the medial malleoli. A slight degree of muscular atrophy may be overlooked unless careful measurements of the circumference of the thighs and calves are made at definite levels. Measurements of the chest during inspiration and expiration will reveal any fixation of the thoracic cage which is often associated with spondylitis deformans.

**Neurological:** The neurological examination should include examination of the sensations for hypesthesia, as determined by pin-prick and light

TABLE No. 2  
Common Intrinsic Causes of Low Back Pain

| MECHANICAL                                                                                                                                                                           | TRAUMATIC                                                                                   | DISEASE                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. Faulty posture                                                                                                                                                                    | 1. Acute and chronic strains (ligamentous or muscular)<br>a. Sacro-iliac<br>b. Lumbo-sacral | 1. Arthritis<br>a. Osteoarthritis<br>b. Rheumatoid (spondylitis deformans)  |
| 2. Scoliosis, functional and structural                                                                                                                                              | 2. Contusions                                                                               | 2. Fibrositis                                                               |
| 3. Kyphosis, juvenile epiphysitis                                                                                                                                                    | 3. Fractures and dislocations                                                               | 3. Osteomyelitis<br>a. Tuberculous<br>b. Pyogenic                           |
| 4. Congenital anomalies of the lumbo-sacral area<br>a. Spondylolysis<br>b. Spondylolisthesis<br>c. Asymmetry of articular facets<br>d. Sacralization (unilateral)<br>e. Spina bifida | 4. Ruptured and intervertebral discs                                                        | 4. Tumors<br>a. Primary<br>b. Metastatic<br>5. Poliomyelitis<br>6. Syphilis |

on the supra-spinous and inter-spinous ligaments, and frequently localizes pain to the involved area in the spine. This test is especially valuable when the patient can not be moved and a severe injury or acute pathology is suspected.

**Chair Test:** (R. E. Burns). With the patient kneeling on the edge of a chair or bench, the legs steadied by the examiner, he is asked to bend over and touch the floor. This can easily be accomplished even in the presence of acute muscle spasm because there is relaxation of the hamstrings, and the motion takes place at the hip joints. This is often of value in detecting malingering or exaggeration, as it can be performed even by persons with complete rigidity of the spine as in spondylitis deformans.

**Jugular Compression Test:** (Naffziger). Jugular compression (by means of a blood pressure cuff with 40 mm. pressure) impedes the venous return from the internal and external jugular veins increasing intracranial pressure and consequently intraspinal pressure—radicular pain in the affected leg is aggravated in intraspinal lesions, i.e., herniated intervertebral discs.

**Jolt Test:** While standing, the patient is asked to rise on his tip toes and drop down on his heels, jolting himself. In vague complaints this may be used to localize the lesion.

**Measurement:** It is important to determine the length of the lower extremities. This can

touch. Temperature testing may be indicated when sensory changes are found. All the common superficial and deep reflexes should be tested. The ankle jerk is frequently absent or diminished in protusions of the fifth lumbar intervertebral disc, but infrequently involved in lesions of the fourth. In lesions of the third disc the knee jerk may be absent or diminished. Saddle anesthesia should be tested for, as it is a definite finding in lesions of the cauda equina.

A new and improved dermatome chart has been devised by J. Jay Keegan and may be found in the *Journal of Bone and Joint Surgery*, Vol. XXVI, No. 2, April, 1944.

X-RAYS

X-rays are imperative in dealing with the problem of low back pain. Many conditions may be overlooked when X-rays are not obtained, therefore, do not wait for someone else to request them. The minimum requirements in all routine examinations are antero-posterior and lateral views of the lumbo-sacral area including the sacro-iliac joints.

Special views are sometimes indicated. The most valuable of these are right and left obliques of the lumbo-sacral area. These views will frequently reveal arthritis or injury to the facets, or defects in the neural arches as in spondylolysis and spondylolisthesis. When a question-



able lesion in a sacro-iliac joint is noted in a flat film, a check film, preferably stereoscopic, with the patient in lithotomy position, is recommended.

Myelography is only necessary in questionable cases of protruded discs, especially those at a higher level. This is not a simple procedure and should be used with caution.

#### LABORATORY STUDIES

Complete blood count, urinalysis, and serology should be routine. A sedimentation rate should be obtained in questionable cases, especially when inflammatory conditions are suspected. If intraspinal pathology is suspected, lumbar puncture is sometimes of value.

Some of the more common intrinsic causes of low back pain are listed in Table No. 2. No detailed differential diagnosis could be included here because of the vastness of that phase of this problem. However, we are including a few points which we feel are of value in detecting malingering, exaggeration and psychoneurosis.

1. There should be a reasonable relationship between the injury and the symptoms complained of, and the objective findings. Occasionally malingerers have learned the clinical picture of some low back disability and give a typical history. However, more usually the symptoms do not fit a definite low back syndrome.

2. Observation of the patient while he undresses often reveals the performance of motions which later under direct examination can not be performed.

3. With organic lesions muscle spasm is usually present, and it is difficult to imitate except momentarily. If muscle tautness is present on prone lying and voluntary contraction is suspected, place one hand under the patient's forehead and have him press downward (against the hand), meanwhile palpating the low back. If muscle contraction is voluntary it will be relieved as he tries to flex his neck.

4. At the beginning of the examination have the patient point out the tender area or areas and mark them with a pen or skin pencil, later check and see if they remain the same. In organic lesions the tender points should remain constant.

5. Chair Test (R. E. Burns)—A malingerer or someone who is intentionally exaggerating symptoms will feel he should be unable to perform this test because it appears to be difficult. Often he will completely flex his lumbar spine in the standing position and refuse to attempt, or attempt but fail to perform this test.

6. As mentioned above, cross-checking of motions will often give one an indication that something is wrong with the clinical picture.

7. The psychoneurotic patient frequently is apprehensive and complains bitterly of pain on any motion of the back or legs, active or passive,

which ordinarily would not be painful in definite low back pathology.

8. Distraction Test. When a patient complains of an exquisitely tender area and this is questionable to the examiner, the patient's attention can be distracted by palpating another region and asking if it hurts there, at the same time palpating the supposedly tender area with the other hand and observing the reaction.

#### SUMMARY

1. A workable approach to the problem of low back pain has been presented in detail.

2. The common intrinsic causes of low back pain have been enumerated.

3. Extrinsic factors, differential diagnosis and treatment have not been included because of the magnitude of the subject.

4. A few aids in the detection of malingering, exaggeration and psychoneurosis have been added.

5. After a careful examination, if there are no clinical or X-ray findings, malingering or exaggeration of mild symptoms must be suspected, especially in military and compensation cases.

#### The Caduceus

The Caduceus which is a wand or slender staff around which are loosely coiled two snakes has at its head two outspread wings. The definition of Caduceus means "herald's wand." The Caduceus was given by the god physician Apollo to Mercury upon the appointment of Mercury as an ambassador to mediate between the gods and man. It has become the magic wand of Mercury, the heavenly messenger of the gods. Mercury is also known to some as the God of Commerce. The Caduceus is a wand from an olive branch signifying peace and the outstretched wings at its head indicate speed and fleetness for the messenger Mercury. The two snakes intertwined about it indicate wisdom for the ambassador. The Roman Army used it as a flag of truce, a symbol of neutrality or peaceful transactions between opposing armies on the battle front. There is no indication that the Caduceus was ever thought in those days to be the emblem of the healing art; however, the fact that it was given to him by Apollo, the god physician, has given rise in some quarters that the Caduceus has a medical significance. It was not until the reign of King Henry VIII that Sir William Butts (.....-1545) personal physician to the king, adopted the Caduceus as his emblem for the medical profession. This is the first record of a physician using the Caduceus for this purpose. A few years later Dr. John Caius presented to Granville and Caius College of Cambridge, England, a silver Caduceus as an emblem of medicine.

# Management of Patients With Prostatic Hypertrophy

## Review of 214 Cases

CHARLES C. HIGGINS, M.D.

IN recent years pronounced progress has been made in the management of prostatic hypertrophy. It has also become obvious that, although the surgical procedure is of paramount importance, minimizing the significance of pre-operative preparation, anesthesia, or postoperative care is attended by progressively increasing morbidity and mortality. Unfortunately the disease is insidious. Many men consider the early urinary disturbances only as indicative of advancing years and accordingly fail to secure medical attention.

The patient may be aware of some hesitancy, frequency, and slowness and lack of force of the urinary stream and subsequently nocturia of increasing frequency. An attack of complete retention may then occur after over-indulgence in alcoholic beverages, exposure to cold, or a long automobile ride. As an alternate to this sequence of events, obstructive symptoms may gradually increase until urine barely dribbles out through the obstructed bladder neck as a result of overflow incontinence.

### EXAMINATION

In patients with prostatic hypertrophy a complete general examination is essential to ascertain the presence of complicating diseases which frequently occur in elderly men. Then by palpation through the rectum a careful rectal examination of the prostate is made. It is well to recall that symptoms of prostatic hypertrophy are not proportional to the amount of enlargement. Thus a large gland that does not encroach upon the vesical outlet does not produce obstructive symptoms so pronounced as those caused by a small gland that does.

After rectal examination the patient is told to empty his bladder completely. A soft rubber urethral catheter is then passed to ascertain the amount of residual urine, and by cystourethrography the degree of intravesical and intraurethral encroachment by the hypertrophied gland is determined. However, immediate cystoscopy is not indicated in all cases. In the aged patient with acute retention or in one with prolonged obstructive symptoms renal function should be estimated before cystoscopy is advised. When nitrogen retention is evident, fluids should be given intravenously and catheter drainage instituted before cystoscopy to prevent precipitating an incipient uremia.

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Intravenous urography unless contraindicated should be done in all cases to determine the condition of the upper urinary tract. Valuable information is obtained concerning renal damage and renal function and whether dilatation of the ureters with coexisting hydronephrosis is the consequence of bladder neck obstruction.

### DIFFERENTIATION

Several conditions may produce symptoms suggestive of prostatic obstruction: (1) Stricture of the urethra is diagnosed by the history and by passage of a urethral catheter. (2) Syphilis may cause cord bladder with a large amount of residual urine. When prostatic hypertrophy and syphilis coexist, cystometric studies should be utilized to determine the causative factor. (3) Carcinoma of the prostate may produce symptoms identical with those of prostatic hypertrophy or may exist simultaneously. It is well known that in certain cases diagnosed prostatic hypertrophy, small areas of carcinomatous tissue are revealed by microscopic section. Rectal palpation, X-ray examination for metastasis, and acid and alkaline phosphatase studies are of value in establishing a diagnosis of malignant lesion of the prostate. (4) Prostatic abscess and prostatic calculus usually can be differentiated by the history, rectal palpation, and X-ray.

In recent years men have become "prostate conscious" probably because of articles on the subject appearing in lay journals. Patients with benign hypertrophy of the prostate without obstructive symptoms rarely require surgery. The elderly man with little or no residual urine and mild obstructive symptoms should have a periodic recheck of the prostate and palliative and expectant treatment. Exposure to cold and excessive use of alcohol should be avoided. Sometimes gentle prostatic massage, urethral dilations, or hot sitz baths may be recommended.



Hormonal therapy may be beneficial. Many such patients may be under observation for years without perceptible increase in obstructive symptoms or amount of residual urine. In such cases prophylactic transurethral resection of the prostate is not indicated and should be condemned.

An appreciation of the value of blood chemistry studies and preoperative care has resulted in a greatly reduced mortality rate for prostatic surgery, 2 to 3 per cent in some series. Preoperative preparation is governed by the general condition of the patient, coexisting diseases such as diabetes, coronary disease and hypertension, and the presence of nitrogen retention. If blood studies reveal evidence of nitrogen retention, intermittent or continuous catheter drainage is employed. When prolonged drainage is required, I prefer suprapubic puncture to continuous catheter drainage. It annoys the patient less and reduces the incidence of urethritis and epididymitis.

#### OPERATION OF CHOICE

No one surgical procedure, in my opinion, is suitable to relieve all cases of prostatic obstruction, and the urologic surgeon should be familiar with the technic of suprapubic, transurethral, and perineal prostatectomy. The procedure finally to be recommended is influenced by the general condition of the patient, the type of hypertrophy, and associated pathologic condition of the bladder. The technic employed by the individual surgeon is that which in his hands produces the best end result with the lowest morbidity and mortality.

With improvement in technic and instruments I believe that transurethral prostatectomy can be satisfactory in 85 to 90 per cent of the cases. When the gland is very large and intravesical intrusion pronounced, I prefer suprapubic prostatectomy. If malignancy is suspected, the entire gland can be removed by perineal prostatectomy. Complication such as stricture of the urethra, malformation of the penis, or numerous false passages may necessitate substituting perineal or suprapubic prostatectomy for transurethral prostatectomy. In my opinion partial removal of the gland is inadequate and will be followed by obstructive symptoms. Almost the entire gland may be removed transurethrally without an increase in operative mortality or morbidity.

#### SPINAL ANESTHESIA

For most cases I prefer spinal anesthesia, although pentothal may be used when smaller glands are to be removed by transurethral or suprapubic prostatectomy. Caudal anesthesia as recommended by some surgeons is also satisfactory.

The significance of postoperative care cannot be minimized. Maintenance of normal acid-

base equilibrium and fluid balance, adequate nursing care, and early recognition of complications are essential.

The surgeon's care of the patient does not terminate with the surgical procedure. When discharged the patient should be able to empty the bladder completely, which should be free from infection. Obstructive symptoms should be entirely relieved, and the control should be normal.

At the Cleveland Clinic from January 1, 1943, to January 1, 1944, I operated upon a series of 214 patients with a diagnosis of bladder neck obstruction.

An analysis of the findings follows:

**Age.** The average age was 65.2 years. The oldest patient was 87 and the youngest 38 years of age. One, aged 49, had a contracted bladder neck and 220 cc. of residual urine.

**General complications.** That heart disease frequently associated with hypertension is the major complicating factor is evident from Table 1. For

TABLE 1. GENERAL COMPLICATIONS FOUND

|                                                                               |    |
|-------------------------------------------------------------------------------|----|
| Heart disease .....                                                           | 70 |
| Generalized arteriosclerosis .....                                            | 20 |
| Hypertensive arteriosclerotic heart disease .....                             | 20 |
| Arteriosclerotic heart disease .....                                          | 13 |
| Hypertensive heart disease .....                                              | 6  |
| Hypertensive arteriosclerotic heart disease with auricular fibrillation ..... | 5  |
| Arteriosclerotic heart disease with angina .....                              | 2  |
| Cor pulmonale .....                                                           | 1  |
| Arteriosclerotic heart disease with block .....                               | 1  |
| Syphilitic heart disease .....                                                | 1  |
| Aortic stenosis .....                                                         | 1  |
| Other complications .....                                                     | 26 |
| Diabetes mellitus .....                                                       | 5  |
| Emphysema .....                                                               | 4  |
| Bronchial asthma .....                                                        | 4  |
| Parkinson's disease .....                                                     | 3  |
| Left facial paralysis .....                                                   | 2  |
| Duodenal ulcer .....                                                          | 2  |
| Central nervous system syphilis .....                                         | 2  |
| Pyelonephritis .....                                                          | 2  |
| Pernicious anemia .....                                                       | 1  |
| Chronic cholecystitis .....                                                   | 1  |
| Total .....                                                                   | 96 |

this reason it has been my policy to have a cardiologist see all patients in consultation prior to operation, which, in my opinion, has definitely been attended by a lowering of operative mortality.

Seventy-three patients, or 34.1 per cent, had complete urinary retention when admitted to the hospital. The residual urine averaged 204 cc. in 102 patients. As the rest, with few exceptions, had chronic urinary retention and were slowly decompressed, the residual urine could not be

measured. I prefer to avoid sudden decompression when the bladder has been subject to prolonged overdistention.

Suprapubic puncture was employed in 17 per cent of the cases and in most cases was preceded by two or three days of drainage by an indwelling catheter. This was considered preferable to continued drainage by an indwelling catheter. It was quickly performed under local anesthesia and was not accompanied by any complication.

OPERATIVE RESULTS

The operations are classified in Table 2. The amount of tissue removed by transurethral resection is obviously influenced by the size of the

TABLE 2. OPERATIONS PERFORMED

|                                  |     |
|----------------------------------|-----|
| Suprapubic prostatectomy.....    | 16  |
| One stage operation.....         | 10  |
| Two stage operation.....         | 6   |
| Perineal prostatectomy.....      | 1   |
| Transurethral prostatectomy..... | 197 |
| One stage operation.....         | 183 |
| Two stage operation.....         | 14  |
| Total.....                       | 214 |

prostate and the type of obstruction, smaller amounts being removed for median lobe hypertrophy, bars, and contracted bladder necks. An average of 21.2 Gm. was removed by the transurethral technic; this figure also includes operations in which less tissue, i.e., bars, median lobe hypertrophies, and contracted vesical necks, was removed. By suprapubic prostatectomy an average of 34.3 Gm. was removed, excluding the largest gland which weighed 103 Gm. The gland removed from the single case in which perineal prostatectomy was performed weighed 28.9 Gm. The average weight of tissue removed transurethrally after a diagnosis of carcinoma of the prostate had been made clinically was 12.9 Gm.

Nineteen patients had transurethral resections previously. Upon one patient with benign hypertrophy of the prostate I performed a transurethral resection in 1940. I operated upon 1 patient in 1941, and upon 6 patients, 4 of whom had carcinoma, during the previous five-year period. The other patients were operated upon elsewhere and obstructive symptoms recurred. It is of interest to note that 10 of the 19 patients requiring a second operation had carcinoma of the prostate.

For transurethral resection the average hospital stay was 11.3 days, for suprapubic prostatectomy 21.3 days, and for the single case of perineal prostatectomy 22 days.

In 6 patients postoperative bleeding occurred the day of operation. This was readily controlled by fulguration of the bleeding point and evacuation of clots. Although obvious oozing occurred to

some degree in other cases, it rapidly subsided under adequate irrigation. Delayed bleeding occurred in 9 patients between the thirteenth and thirtieth days. In 5 patients fulguration of the bleeding point was deemed advisable, while in the other 4 insertion of a urethral catheter was followed by prompt cessation of oozing.

TABLE 3. MAJOR POSTOPERATIVE COMPLICATIONS

|                               |    |
|-------------------------------|----|
| Epididymitis.....             | 11 |
| Bronchopneumonia.....         | 5  |
| Coronary thrombosis.....      | 2  |
| Cerebrovascular accident..... | 1  |
| Pulmonary embolus.....        | 1  |
| Delirium tremens.....         | 1  |
| Extravasation of urine.....   | 1  |

Table 3 lists the major complications arising after operation. Minor complications responded favorably to treatment.

Mortality. Six patients died after operation, an operative mortality of 2.52 per cent (Table 4).

TABLE 4. CAUSE OF DEATH

|                                            |   |
|--------------------------------------------|---|
| Cerebrovascular accident.....              | 1 |
| Uremia.....                                | 1 |
| Circulatory failure.....                   | 1 |
| Streptococcus fecalis septicemia.....      | 1 |
| Carcinoma of prostate with metastasis..... | 1 |
| Pulmonary embolism.....                    | 1 |
| Total deaths.....                          | 6 |

The remaining patients were discharged in satisfactory condition.

Of 28 patients upon whom transurethral resection was performed for carcinoma of the prostate, 20 had subsequent bilateral orchiectomy. During the later months of 1943 the use of stilbestrol replaced bilateral orchiectomy in most cases.

Incontinence occurred in 2 cases of carcinoma for which transurethral resection was performed. Incontinence was not complete and did not require the use of a bag or clamp. Although a few patients had temporary dribbling upon coughing or straining for a few days after transurethral resection, the incontinence was not permanent.

CONCLUSION

Individualization of patients with prostatic hypertrophy is essential. In elderly men the frequent occurrence of general complicating diseases makes ample consultation with the internist and cardiologist advisable. Adequate preoperative preparation and postoperative care are required to maintain a low operative mortality and morbidity. A series of 214 cases operated on for prostatic hypertrophy at the Cleveland Clinic between January 1, 1943, and January 1, 1944, is reviewed. The mortality in this series was 2.52 per cent.



# The Second Report of Prophylaxis of Post-Tonsillectomy Granulation Oozing

C. ARBUTHNOT CAMPBELL, M.D.

THIS is the second report of the medical prophylaxis of post-tonsillectomy granulation oozing. Reporting 198 unselected cases of tonsils and/or adenoid removal using menadione (vitamin K) and later in this series adding ascorbic acid (vitamin C) as an added preventative for oozing. The first report (*Ohio State Medical Journal*, Dec, 1943) on 225 A. & T. cases. These 198 cases are unselected and of the middle and the lower economic status, as of the average private practice. The average ages between 5 and 20 years although a few lower and higher. Color 98 per cent white.

A brief review of the first article: Reports stating 10 per cent to 60 per cent of avitaminosis exists depending upon the reporter and his location. It seems vitamin K may be as deficient in as corresponding a degree and frequency as the other vitamins. If vitamin K is as deficient or a borderline status at the time of tonsillectomy, the post-tonsillectomy fasting, especially in adults and older children, would increase this deficiency. If this rationale is correct, then avitaminosis (of various degrees) could predispose to granulation oozing; plus throat trauma such as coughing, expectorating, swallowing of coarse foods, etc. As young children return to their regular diet more promptly than older children and adults, they have less frequent granulation oozing (personal observation).

In first series of 225 cases there was one case of post-tonsillectomy oozing using the original prescription of insufficient vitamin K. And one case of oozing where vitamin K was stopped at operation. Previous to vitamin K my post-tonsillectomy oozing was 3 per cent plus.

In the routine preoperative examination the diagnosis of borderline avitaminosis may be considered of importance, not only for general health and well-being but its apparent relation to hemorrhage: In the papillae of the tongue and cheilitis for B deficiency; and the vessels at the globe of the limbus also for B deficiency. In cases deemed necessary, a dietary history is of sufficient help to make a diagnosis. Of course, cases of frank avitaminosis are not operative cases. The examination of the gums will

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surprise the examiner by the frequency of soft gums that bleed too easily.

In the routine preoperative examination the history of the patient's and family's bleeding is always asked, as occurring in the extraction of teeth, lacerations and ecchymosis. The finger puncture with clotting time in capillary pipettes is of little importance. Blood from the vein for coagulation time is not done.

The local druggists have had quite a delay obtaining powdered menadione from the manufacturers. In such delays the tablets of menadione are titrated and added to the ascorbic acid powder and put into the smaller capsules.

Menadione (vitamin K) seems to function for the formation of prothrombin. If the patient has a deficiency of prothrombin that patient develops hypoprothrombinemia. Hypoprothrombinemia is one of the causes of bleeding by increasing the clotting time. Hemorrhages of the newborn, as shown by statistics, are improved by menadione. From personal report, many are giving menadione as a routine in obstetrics. It has been suggested that bile salts be added to the menadione to aid absorption. The hemorrhagic diathesis, hemophilia, is not considered in this paper.

The ascorbic acid (vitamin C) is added to the prescription for the cement action on the capillaries. In cases having undiagnosed vitamin C deficiency, the value is obvious and should be of value with the reduced diet of convalescence. No emphasis has been placed on the value to tissue healing. Vitamin K was used only in 63 cases and judgment is withheld until more cases have used it, although I saw no benefit from its use. However, vitamin K is harmless in the dosage prescribed.

The prescription is started four days before operation to have absorption at time of operation and is continued 11 days after. But is not given the day of the operation. If the opera-

tive fields have not epithelized by the 11th or 12th day, the vitamins K and C should have accumulated sufficiently to last for the few days necessary for the epithelization to be completed. I have not examined a sufficient number of post-adenoid operative fields to know the time of epithelization, but I have found the time is influenced by the size of the operative field.

The average patient usually has some knowledge of operative tonsillectomy hemorrhage, but they know little of granulation oozing. Therefore, it has been my experience that it is necessary to gently and firmly impress upon the patient to continue medication until all capsules are taken, and upon the patient's first post-operative visit to discover if patient is following directions.

In this series the following is the report of 3 cases of post-operative bleeding:

**Patient G. A.** 5 years, white, female. Had measles and chickenpox. Repeated winter rhinitis and tonsillitis. Palpable cervical glands. No suspicious allergy history. No sickness two weeks before operation. Routine physical examinations prior to operation were negative, including fluoroscope of lungs, no evidence of upper respiratory infection. Laboratory negative.

Operation routine and without incident. Patient in semi-private (2-bed) room and returned home day after operation. Just as my patient was leaving I discovered the second patient in the room had a mild upper respiratory infection. Four days after operation parents phoned that patient had an oral and nasal hemorrhage and rhinitis. Patient immediately brought to office but the bleeding had stopped and the patient had on examination an acute purulent naso-pharyngitis. Covering a period of a week the patient had four hemorrhages, but none of severity either by volume or duration. Between 10 and 12 days the purulent naso-pharyngitis subsided and recovery was uneventful. Patient had taken menadione as prescribed.

**Patient M.A.S.** White, female, 16 years. History and examination all negative. Operation routine and uneventful. On evening of sixth post-operative day patient telephoned she had been expectorating some blood, refused office treatment that night as unnecessary. The next morning examination showed no evidence of bleeding, granulations of the fossae normal. No further bleeding and recovery uneventful. Patient stated she had taken menadione as prescribed.

**Case E.B.Y.** White, female, aged 9 years. History and examination including fluoroscope, negative; except some prominence of tongue papillae anteriorly, no cheilitis. Routine operation without incident. On the seventh post-operative day patient came to office stating she had some bleeding the previous night. Upon examination there was a small, round hemorrhage bleb about 4 mm. in diameter, firm, dark purple in color, on the upper third of the posterior pillar of right fossa. No fresh blood present. Patient said she had not stopped her prescription of menadione. Uneventful recovery without further bleeding.

There are several reasons for these post-operative bleedings. Case No. 1 was a frank case of purulent rhino-pharyngitis and I assume was the cause of hemorrhage; the prophylaxis in this case would be prevention of the rhino-pharyngitis. Cases Nos. 2 and 3 could be caused by one or a combination of the following factors: (A) Insufficiency of menadione intake (in prescription). (B) Deficiency or absence of ascorbic acid (not given in these cases). (C) A constitutional unknown to me reducing the absorption and/or assimilation of menadione. (D) Improper home activity: For example, several years ago a 14-year old boy had severe bleeding post-operatively; he had been practicing football from the second day after operation, resulting in bleeding. Or the case of the adult woman scraping her throat with her finger nail to relieve secretion in post-operative throat. (E) Until more cases are reported and judgment of their results are more accurate, the patients' statements of continuing their medication will be accepted.

The cause and effect of surgical trauma producing post-tonsillectomy oozing should be a reality because smaller the operative field and the least injury to adjacent tissue with preservation of the fascia, the minimum time will be required for healing and epithelization with less granulation in the smallest operative field. The importance of delaying tonsillectomy until the complete return to normal after acute inflammatory pathology of the respiratory system must be strictly enforced for the best results. We recently observed three tonsillectomies performed too soon after the disappearance of the acute symptoms of naso-pharyngitis that resulted in a hemorrhage in each patient, although one hemorrhage occurred too soon, 14 hours, after operation to be from granulation. The relation of bacteria flora of the mouth to granulations and hemorrhage has not been considered.

#### SUMMARY

In the original article reporting 225 tonsillectomies in which vitamin K 2 mg. was given once a day there was a marked reduction of the number of cases of granulation oozing. This report of 198 cases had three cases of granulation bleeding, viz.: One case of purulent rhino-pharyngitis requiring treatment, and two cases not requiring treatment. Before using vitamin K, with or without vitamin C my granulation oozing was 3 per cent plus. The addition of vitamin C (ascorbic acid) is of unknown value. More cases using vitamin K will aid forming an opinion. Granulation oozing by the frequency or amount can be an alarming symptom to the patient and the relative and embarrassing to the physician, especially when recurring.



# Erythroblastic Anemia—Mediterranean Disease in An Adult: Report of An Unusual Case\*

JOHN T. READ, M.D.

**R**ECENT reports<sup>1,2</sup> have drawn attention to the occurrence of familial erythroblastic anemia (Cooley's anemia) in adults, which is considered to be a benign form of the disease with an apparent hereditary defect in the hematopoietic system.

The case reported here demonstrates the classical blood findings of marked anisocytosis, poikilocytosis, target cells and nucleated erythrocytes with splenomegaly, hepatomegaly and decreased fragility of red cells. The usual family history and X-ray findings of osteoporosis and increased trabeculation of the bones of the extremities and skull were lacking. The similarity of the above findings to Mediterranean disease seems to justify our considering this patient as having a benign form of the fatal disease which Cooley described in young children. Because of the unusual character and apparent extremely rare occurrence of the condition to be described it seemed worth while recording.

## CASE REPORT

The patient, a male, aged 36, when first seen six months ago in India was complaining of chills, fever, fatigue and a yellow skin. A diagnosis of benign tertian malaria (*P. vivax* demonstrated) "a moderate infestation", was made and he was treated with atabrine, (4.5 gr., daily) for seven days. This episode entirely remitted without complications or recurrence. It was noted that his spleen and liver were enlarged when he was first examined in India. During the course of hospitalization there the Kahn test was repeatedly positive and was not influenced by small doses of mercury and iodides. For this reason he was returned to the United States to this hospital.

Since admission here he complained chiefly of fatigue.

He had the usual childhood diseases and occasional sore throats. He stated that he had "inflammatory rheumatism" at the age of 8 or 9 years. A pilonidal cyst was removed 5 years ago. The patient said that he had been having recurring attacks of jaundice for the past 3 or 4 years which would last for 2 or 3 weeks and then subside. During this entire period of at least 3 years he felt that his abdomen was gradually becoming larger. He denied the presence of any penile lesion or any generalized dermatitis.

The patient's parents were born in Italy. His mother and father are living and well. One brother and one sister are living and well. He knew of no familial disease or history of jaundice in his immediate family.

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Submitted January 2, 1945.

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On examination the patient was a short, stocky, dark complexioned man who was noticeably jaundiced. The abdomen was moderately protuberant and rotund. The conjunctiva, sclera and the buccal membranes were jaundiced. On auscultation of the mitral area a short, soft systolic murmur was heard but was not transmitted, no thrill was palpable. The spleen was enlarged, smooth and firm, extending to the midline and upon standing was palpable at the level of the left iliac crest. It was freely movable and nontender. The right liver margin could be felt about two finger breadths below the right costal margin. The remainder of the examination was entirely normal.

Roentgenograms taken shortly after admission showed a normal chest, the hands showing slight narrowing of several of the inter-phalangeal joints, giving the appearance of an atrophic type of arthritis. The skull and bones of the extremities were entirely normal. Stereoscopic films of the abdomen showed marked enlargement of the spleen and moderate enlargement of the liver. The kidneys were normal in size and position.

Electrocardiographic studies showed a small Q-2 and 3, which were believed to be normal as no clinical symptoms of cardiac pathology were demonstrated aside from the murmur previously recorded.

## LABORATORY DATA

The initial laboratory data as mentioned before showed a positive malaria smear, plasmodium vivax being found. Repeated films on succeeding occasions for the past 5 months have all been negative.

2. Several Kahn tests were positive. Quantitative tests were not performed until 2 months after the initial study.

3. Repeated blood counts showed a slight anemia. The red count varied between 3,500,000 and 4,100,000. Hemoglobin determinations ranged from 8.0 to 9.5 gm. White blood counts varied between 3,900 and 8,500 with an essentially normal differential. Reticulocyte and platelet counts were within normal limits.

4. The icterus index ran between 20 and 24 and the Vandenburg showed a positive indirect reaction with 2.0 to 3.5 mg. per cent to bilirubin.

5. The spinal fluid showed a flat colloidal gold curve, no globulin and no cells were present.

Laboratory data accumulated in this country demonstrated a moderate anemia, the corpuscular indexes calculated (the mean corpuscular volume, mean corpuscular hemoglobin and the mean cor-

puscular hemoglobin concentration) were within normal limits. The erythrocyte fragility showed increased resistance to hemolysis, the initial hemolysis began at 0.40 and was not complete at 0.28.

Hippuric acid and brom-sulfalein liver function tests were within normal limits. The urobilinogen excretion in several 24 hr. urine samples was not increased above normal.

Repeated examinations of the peripheral blood showed approximately 3 normoblasts per 100 red blood cells. There was a marked degree of anisocytosis and poikilocytosis, many target cells and many polychromatophilic cells were present. The aspirated sternal marrow was normal except for an altered ratio of erythroblasts to normoblasts which was approximately 1:1.

Sickle cell preparations were normal. It was observed on supravital slides that the target cells were apparently being formed by the fragmentation of the central area of the erythrocytes. A small, rounded portion of the central area would break off, being connected to the body of the cell by a thin strand of cytoplasm. This fragment was observed to pinch off from the parent cell on several occasions.

Repeated Kahn and Wassermann tests were positive. The quantitative Kahn tests ranged between 20-10 units, no higher titre was found in three months observation.

Stool examinations were normal.

#### COURSE AND THERAPY

In addition to his treatment for malaria previously mentioned, small doses of bichloride of mercury gr.  $\frac{1}{4}$  intramuscularly and a saturated solution of potassium iodide, 20 drops three times a day, caused no alteration to the positive Kahn test. After admission to this hospital eight 0.30 gm. doses of mapharsen were administered with no change in the quantitative Kahn test.

The patient received no specific therapy for his anemia.

#### DISCUSSION

A few cases have been reported recently in the adult which were typical instances of erysical X-ray manifestations, blood findings and throbastic anemia.<sup>1,2</sup> They showed the clasp-family history of Mediterranean disease. Our case, however, shows the reticulo-endothelial defect only and no family history of the reputedly typical skeletal changes. The familial character of the disease has been clearly demonstrated.<sup>3,4</sup> Apparently all gradations of the disease or defect may occur from a solitary involvement of the erythrocytes, to the entire complex.

The complicating factors in the diagnosis of this patient's condition were the presence of a positive Kahn test and the history of an acute episode of benign tertian malaria. However, the absence of the clinical signs and history of primary, secondary or tertiary lues and a quantitative Kahn titre, not above 1-20, would make a diagnosis of syphilis not only hazardous but unlikely. A titre of 1-80 or over which increases or remains stationary may be confirmatory evidence of syphilis, especially if it falls rapidly with antiluetic therapy, neither of the above were true in this case.

As the splenomegaly and hepatomegaly were found concurrently with the first and only attack of malaria, this disease was not thought to be responsible for their presence.

The patient had had recurring attacks of jaundice for 3 or 4 years prior to his hospitalization. This fact, plus the patient's statement, that, "my abdomen has been increasing in size for 3 or 4 years", lends credence to the assumption that the hepatomegaly, splenomegaly and other reticulo-endothelial disturbance antedated the present study.

Wintrobe<sup>4</sup> and Dameshek<sup>5, 6</sup> have studied families and their relatives in which the disease was fully developed or in whom variants of the defect were observed. Caminopetros<sup>7</sup> observed the familial character of the disease wherein both dominant and recessive Mendelian tendencies were encountered. He also mentioned cases in which a decreased erythrocyte fragility was the only finding.

Dameshek demonstrated the relationship between "target cell anemia" and Cooley's Anemia in persons of Italian stock and he surmised that the former was a part of Cooley's Anemia complex.<sup>5</sup>

The patient discussed here demonstrates another variant, i.e., marked splenomegaly and hepatomegaly with typical blood and bone marrow findings, lacking, however, the skeletal changes and family history. We believe that this patient suffers from an arrested or benign form of the disease and has apparently inherited the recessive trait. Nevertheless, he should be capable of begetting children with the full-blown fatal disease.

#### CONCLUSIONS

1. A case of erythroblastic anemia in an adult without family history or the complete disease complex being present is reported.
2. It is believed that all gradations of Mediterranean disease may present themselves, ranging in scope from involvement of the erythrocytes only, to the presence of the entire disease complex.
3. A "false" positive Kahn test due to malaria led to an erroneous diagnosis in the case here recorded.
4. Supravital studies revealed that target cells seemed to be formed by fragmentation of erythrocytes.

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# Clinical Observations on the Use of Cotton as A Suture Material\*

WILLIAM PAUL KANNE, M.D., and WILLIAM EGGERS SMITH, M.D.

OUR interest in the use of cotton as a suture material was stimulated by the recent reports and complementary papers in the current literature.

The use of cotton as a suture material is by no means new. As early as 500 B. C., Susruta<sup>1</sup> recommended the use of cotton suture in wounds of the abdomen and joints. In 1936 Ginkorski<sup>2</sup> published an article on the use of cotton suture material. Since 1939 there have been several fine papers on this subject by Word and Brock,<sup>3</sup> Meade and Ochsner,<sup>4</sup> Nelson and Collins,<sup>5</sup> Meade and Long,<sup>6</sup> and others.<sup>7</sup>

To evaluate and make more poignant the advantages or disadvantages claimed of cotton as a suture material we began the study of a series of cases. In these cases cotton has been used throughout the entire surgical procedure with the exception of the peritoneal closure for which we used No. 0 chromic catgut.

## MATERIALS USED

No. 60 quilting cotton has been used for subcutaneous tissue bleeders and subcutaneous tissue approximation. No. 24 quilting cotton has been used for larger vessels, fascial closures, approximation of muscle tissue, for peritoneal closure, and for skin closure. No. 8 crochet cotton or No. 10 quilting cotton has been used for tying of appendiceal stumps, large vessels, and for stay sutures.

## A REVIEW—EFFECT OF WETTING, KNOTTING AND IMPLANTATION INTO TISSUES

We all know that suture material in general is altered by wetting, by knotting, and by actual implantation in animal tissue. Meade and Oschner<sup>8</sup> found that after wetting most sutures lose from 30 to 60 per cent of their original tensile strength. Compare, for instance, the following: A piece of catgut with an original tensile strength of 21 pounds had only 15 pounds tensile strength after wetting; silk with an original tensile strength of 3.1 pounds had only 2.2 pounds tensile strength after wetting; linen has no loss of tensile strength by wetting, but if boiled for 5 minutes loses 30 per cent of its original tensile strength; cotton, on the other hand, has no loss of tensile strength on wetting, and boiling actually increases the original tensile strength by 10 per cent.

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Knotting causes a loss in original tensile strength of all suture materials. The weakness occurs just directly on either side of the knot. Generally speaking, the finer the suture material the less percentage loss of tensile strength. Compare the following:

| Material Used        | Loss in Original Tensile Strength by Knotting |
|----------------------|-----------------------------------------------|
| Catgut No. 0         | 40 Per Cent                                   |
| Silk, coarse         | 33 Per Cent                                   |
| Silk, fine           | 24 Per Cent                                   |
| Linen, coarse        | 48 Per Cent                                   |
| Linen, fine          | 43 Per Cent                                   |
| Cotton No. 12-No. 30 | 35 Per Cent                                   |
| Cotton No. 50-No. 80 | 28 Per Cent                                   |

Meade and Ochsner<sup>8</sup> have shown very effectively the change in suture material after implantation into animal tissue. In this study they found that catgut lost 30 per cent of its original tensile strength in 4 days, 50 per cent in 7 days and 60 per cent in 10 days. Silk lost 20 per cent of its original tensile strength in 4 days, 50 per cent in 7 days, and 41 per cent in 10 days. Linen lost 21 per cent of its original tensile strength in 4 days, 30 per cent in 7 days, and 40 per cent in 10 days.

Cotton, on the other hand, showed no appreciable loss in its original tensile strength in the first 7 days. From the 7th to 10th days there was about 1 per cent loss of original tensile strength.

From this short review the advantage of using cotton can then be plainly seen. Between the 4th-10th days (the critical period of wound healing) when other sutures have lost from 30 per cent-60 per cent of their original tensile strength, cotton, for all practical purposes, maintains its original tensile strength. It can be surmised

\* From the Surgical Service of Fairview Park Hospital, Cleveland, Ohio. Submitted March 21, 1945.

that wound healing would be greatly aided by this factor and that early ambulation could be more safely practiced.

#### CHANGE OF SURGICAL TECHNIQUE

Changing from catgut to cotton was quite interesting. For cotton becomes a most exasperating material with which to work. It is continually breaking; it sticks to everything, dry or wet; it invariably pulls out of the needle eye; and it is limp and at first seems to have no life; last, but not least, operating time is found to be increased by 15 per cent to 20 per cent.

All these seemingly undesirable features soon disappear with the constant use of cotton suture material. After a bit of practice we found that if knots are tied deftly but with care and precision the cotton does not break; that if small bits of tissue or the vessels themselves are grasped for tying, extremely fine cotton can be used for ties and the cotton will not break; mass ligation and consequent strangulation of tissue is to be avoided. In this series all interrupted sutures have been used. Sutures have been tied with three throws and the suture cut on the last knot. Each layer has been carefully approximated and all dead space eliminated. In other words, we found that to use cotton one must "brush" up on one's surgical technique. And that if you adhere rigidly to the tenets of Halstead<sup>3</sup> while using cotton as a suture material the results obtained, from a clinical and surgical viewpoint are better than those obtained with other suture material.

#### TYPES OF SURGICAL PROCEDURES

In this series we are reporting 60 cases on which 80 surgical procedures were performed. This is to be considered a preliminary report. The following list shows the type of operative procedure in which cotton suture material was used:

##### Herniorrhaphies

|                  |   |
|------------------|---|
| Ventral .....    | 4 |
| Inguinal .....   | 7 |
| Femoral .....    | 3 |
| Incisional ..... | 1 |

##### Appendectomies

|                    |   |
|--------------------|---|
| McBurney's .....   | 5 |
| Right Rectus ..... | 9 |

##### Laparotomies

|                                                            |  |
|------------------------------------------------------------|--|
| Uterine suspension and incidental Appendectomies (5)       |  |
| Hysterectomy                                               |  |
| Posterior Gastroenterostomy                                |  |
| Resection of Sigmoid                                       |  |
| Exploratory—Biopsy (3)                                     |  |
| Plastic to Right Tube                                      |  |
| Fundectomy                                                 |  |
| Hysterectomy and Oophorectomy                              |  |
| Uterine Suspension, Salpingo-oophorectomy and Appendectomy |  |
| Perineorrhaphy, Bilateral Salpingectomy, Appendectomy      |  |
| Closure of Perforated Peptic Ulcer                         |  |

Salpingo-oophorectomy and incidental Appendectomy  
Hysterectomy and Bilateral Salpingectomy  
Colostomy-Sigmoid  
Anterior and Posterior Colporrhaphy, Bilateral Salpingectomy  
Exploratory with Appendectomy.

##### Miscellaneous

Orchidectomy  
Cholecystectomy (2)  
Hemorrhoidectomy  
Mastectomy, Simple  
Removal Coccyx  
Thyroidectomy  
Mastectomy, Radical  
Excision of Fibro-myoma of Internal Oblique Muscle

#### CLINICAL OBSERVATIONS: THE WOUND

All wounds were left untouched until the 5th to 7th post operative day respectively when the skin clips or cotton skin sutures were removed.

All wounds of this series healed by first intention or primary union.

There was no sign of infection or tissue reaction if the skin sutures were removed up to and including the 7th day. On the 8th, 9th and 10th days there was a very small amount of redness about the emergence of the cotton sutures.

The wound is as soft and pliable as the surrounding skin. There is no induration, redness, or spreading of the scar.

There have been no eviscerations, dehiscence, or wound disruptions. To date there have been no incisional hernias.

We have noticed only one complication in so far as the wound is concerned. This complication occurred five times in this series as follows: On the 12th to 18th postoperative day, somewhere along the incision, a small vesicle formed. In a few days this vesicle ruptured and the end of a cotton suture protruded. This spot then remained open until further treatment was instituted. In three of the five cases the free end of the suture was grasped and cut off, deep under the skin. In two of the five cases the suture was removed. In all five cases the wound healed promptly without further trouble after cutting off the protruding suture end or by removing the suture. This complication occurred early in the series and only in thin patients with little or no subcutaneous fat layer. We have since learned that if a good layer of subcutaneous fat is drawn together over the fascial sutures with fine cotton and that if sutures are not placed directly under the skin this complication does not occur. There has been no recurrence of this complication in the last 40 cases. We attribute this fact to the above corrected technique.

#### EARLY AMBULATION

In this series early ambulation was encouraged. An explanation of what we were doing was given to the patient with the suggestion that if he



(the patient) so desired he might dangle or get out of bed in a chair in the first 24 hours. Most patients were interested and cooperated splendidly. The following table shows the time of ambulation:

| "Dangling" |               | Per Cent |
|------------|---------------|----------|
| 1st        | P.O. day..... | 54.4     |
| 2nd        | P.O. day..... | 12.3     |
| 3rd        | P.O. day..... | 10.5     |
| 4th        | P.O. day..... | 1.7      |
| 5th        | P.O. day..... | 7.0      |
| 6th        | P.O. day..... | 0.0      |
| 7th        | P.O. day..... | 1.7      |
| 8th        | P.O. day..... | 0.0      |
| 9th        | P.O. day..... | 0.0      |
| 10th       | P.O. day..... | 5.3      |
| 11th       | P.O. day..... | 3.5      |
| 12th       | P.O. day..... | 1.7      |
| 13th       | P.O. day..... | 1.7      |
| 25th       | P.O. day..... | 1.7      |

| "Out of Bed" |               | Per Cent |
|--------------|---------------|----------|
| 1st          | P.O. day..... | 17.5     |
| 2nd          | P.O. day..... | 31.6     |
| 3rd          | P.O. day..... | 12.3     |
| 4th          | P.O. day..... | 5.3      |
| 5th          | P.O. day..... | 3.5      |
| 6th          | P.O. day..... | 5.3      |
| 7th          | P.O. day..... | 10.5     |
| 8th          | P.O. day..... | 1.7      |
| 9th          | P.O. day..... | 1.7      |
| 10th         | P.O. day..... | 1.7      |
| 11th         | P.O. day..... | 7.0      |
| 12th         | P.O. day..... | 0.0      |
| 13th         | P.O. day..... | 1.75     |
| 25th         | P.O. day..... | 0.0      |

#### CONCLUSIONS OF EARLY AMBULATION

All patients that got up out of bed in the first three postoperative days described a "soreness" at the operative site. This was described as a dull ache rather than a sharp pain. After the third postoperative day this sensation disappeared.

Of all the patients in this series there were only three who had to be catheterized postoperatively.

All but 7 per cent of the patients of this series were free from "gas" pains postoperatively.

There was much less difficulty with constipation and defecation. Forty per cent of the patients of this series had spontaneous bowel movements before the routine third postoperative day cathartic was given.

There has been one case of unilateral thrombophlebitis. This followed a very difficult panhysterectomy in which there were innumerable adhesions.

There have been two deaths in this series. One was a 67 year old woman, a known cardiac for many years with generalized arteriosclerosis, who came in with an acute upper respiratory infection, and complaining of severe lower right

quadrant pain which she pointed out as localizing over McBurney's point. She was also nauseated and had an elevation of temperature. Laboratory examination of blood and urine established the possibility of an acute appendicitis. The pathological report was obliterative appendicitis. This patient was debilitated and remained in hospital for four weeks after operation and then suddenly died. Postmortem showed an old infarction of the right kidney (which we assume was the cause of her original symptomatology and right lower quadrant pain) and a recent pulmonary thrombus with infarction of both lungs. The second death was a case of carcinoma of the colon with carcinomatosis and death. It is evident that neither of these deaths can be attributed to either the use of cotton or to early ambulation.

All patients of the series who ambulated early were surprised at the very little strength they had lost because of the operation. Objectively they also appeared stronger and seemed to make an early recovery.

Ninety-five per cent of the patients were enthusiastic over the early ambulation.

We realize and recognize that there are definite contraindications for early ambulation such as:

Generalized peritonitis,  
Pneumonias,  
Severe cardiac conditions,  
Thyroid storm,  
Marked emaciation and debility,  
Situations in which there is unstable wound closure.

Another point to remember, as far as early ambulation is concerned, is that though we wish to get the older operative patient up early to prevent pulmonary and vascular complications we must keep in mind a possible already present thrombus in the vascular tree or a heart which would be a source of emboli. In such cases early ambulation may actually precipitate a pulmonary thrombus.

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# Allergic Manifestations to Sulfamerazine, with Two Case Reports of Anuria in Children

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HERE are numerous references in the literature to hypersensitivity to the sulfonamides, and there are consistent reports of a similar nature with the advent of new compounds to this series of chemotherapeutic agents. It is a generally accepted fact that many of the toxic manifestations are on an allergic basis.<sup>1, 2, 3, 4</sup>

## MECHANISM

Evidence is accumulating from animal experimentation which supports the concept of sulfonamide hypersensitivity. Landsteiner<sup>5</sup> has shown that immunologically active antigens may be synthesized by conjugating pure chemicals with animal sera or other proteins, the combination resulting in an antigen possessing a high degree of specificity. Further, antigen specificity has been shown to depend upon the chemical radicle and not upon the protein fraction of the conjugated antigen.

Wedum<sup>6</sup> was able to sensitize guinea pigs to azoproteins prepared from the sulfonamides, proving such sensitivity by anaphylaxis and precipitin tests. He also demonstrated that the reactions are not absolutely specific as there may be interreactions between the various sulfonamides. More support to the immunological specificity of sulfonamide protein conjugates is lent by the recent experiments of Gerber and Gross,<sup>7</sup> who were able to produce the Schwartzman phenomenon in rabbits as well as anaphylaxis in guinea pigs with a wide variety of drugs—sulfacetamide, sulfanilamide, sulfathiazole, and sulfanilic acid.

Longcope<sup>4</sup> in a comprehensive analysis relates animal sensitization to sensitization of the human being with pure chemicals. He states that repeated contact with a given chemical leads eventually to the formation of an antigen constructed from a combination of the chemical with the body proteins of the individual. After sensitization has occurred, an allergic reaction results from intimate contact with the chemical: An early reaction, analogous to the immediate or accelerated form of serum disease, is probably caused by the chemical alone; a reaction slow in onset, analogous to serum sickness itself, is probably preceded by the conjugation of the chemical with the body protein. His views are

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substantiated by reference to reported cases of sulfonamide hypersensitivity. Ratner<sup>2</sup> is of the same opinion concerning the relationship of the so-called toxic reactions to the sulfonamides and serum allergy.

The demonstration of sensitivity to the sulfonamides by means of skin tests has in the majority of instances been unsuccessful. The fact that Leftwich<sup>8</sup> has developed a method of skin testing that has shown a high percentage of reliability in individuals giving evidence of clinical hypersensitivity, is significant and timely. It adds further evidence to the concept that drug and sulfonamide sensitivity is an allergic reaction, and should be useful as a routine prophylactic procedure in patients who are to receive repeated courses of sulfonamide therapy. It also should be of aid in the differential diagnosis of hypersensitivity and toxicity.

## CLINICAL INVESTIGATIONS

Clinically, the reactions that occur follow a pattern common in a broad sense to all of the sulfonamides. Thus, we find that as each new drug of this group is investigated, toxic manifestations are encountered involving the gastrointestinal tract with nausea and vomiting; the hematologic system with anemia, leukopenia, and thrombocytopenia; the skin with various forms of dermatitis; the genito-urinary tract with hematuria, oliguria and anuria; the thermal regulating center with fever; and the central and peripheral nervous system with psychosis and neuritis.<sup>1, 2</sup>

Sulfamerazine, one of the more recent sulfonamides to undergo clinical investigation, is no exception. It has been studied primarily in an attempt to reduce the renal complications that are not uncommonly associated with sulfadiazine therapy.<sup>9, 10</sup> Welch<sup>10, 11</sup> and Goodwin<sup>12</sup> and their respective groups find, in their studies in the

Acknowledgment is given to: Dr. S. D. Edelman, Assoc. Prof. of Pediatrics, Ohio State University Medical School, for the opportunity to study his patients, while attached to the American Red Cross Blood Donor Center, Dr. Charles A. Doan, Technical Director, Columbus, Ohio.  
Submitted March 19, 1945.



laboratory animal and man, that sulfamerazine is more rapidly and completely absorbed and reaches a higher blood level that is sustained longer than equal doses of sulfadiazine and sulfathiazole; also, that sulfamerazine is more slowly excreted by the kidney and, with its acetyl derivative, is more soluble in urine than sulfadiazine and its acetyl derivative. The solubility of sulfamerazine is nearly doubled with an increase of urinary pH from 6 to 7.<sup>10, 13</sup> Flippin et al.,<sup>9</sup> state that there is less likelihood of crystal and concrement formation in the urinary tract than with sulfadiazine, because of the greater solubility and smaller amounts required to produce a given blood level and therapeutic response.

In a clinical evaluation of sulfamerazine therapy the results in a total of 1,325 patients have been reviewed by five groups of authors.<sup>9, 14, 15, 16, 17, 18, 19, 20</sup> A total of 187 reactions occurred in 149 patients, representing 11.2 per cent of the 1,325 patients treated with sulfamerazine. The only case report of sulfamerazine sensitivity noted in the literature at the time of this writing is a severe pemphigus-like reaction<sup>21</sup> in a 20 year old male. It is interesting to observe that this individual had a course of sulfathiazole medication about one month prior to sulfamerazine therapy, the total dosage of the latter was only 5 grams.

The table summarizes the genito-urinary reactions, of which there were 2.2 per cent involv-

and Spink<sup>18</sup> received a total of 17 gm. of sulfamerazine and had associated flank pain, gross hematuria and crystalluria. A contributory low urinary pH of 4.6 was attributed to concurrent ammonium chloride medication. Cystoscopy revealed the lower ends of both ureters occluded by large crystals of the drug. Urinary flow was re-established with indwelling ureteral catheters and intravenous sodium bicarbonate solution.

In the series of Anderson et al.,<sup>19</sup> one patient developed anuria on the sixth day of therapy—initial dose 2 gm., then 1 gm. every 8 hours—preceded by increasing oliguria for two days. Stoppage of the drug and administration of fluids orally and parenterally relieve the anuria. The first specimen voided contained a large number of crystals. Sulfamerazine was resumed after 24 hours and continued for two more weeks. The length of the period of anuria was not specified in either case.

The low incidence of anuria is of special interest since it was observed in two of 75 children treated with sulfamerazine. Also, because the author is unaware of any previous reports in the literature of sulfamerazine anuria in children.

CASE 1

S.F.M., a 3½ year old white female, who has a definite family history of allergy on both maternal and paternal sides as well as a personal history of allergic rhinitis and repeated colds,

TABLE OF GENITO-URINARY REACTIONS\*

|                 | Flippin et al. <sup>9</sup> |       | Hageman et al. <sup>17</sup> |     | Hall and Spink <sup>18</sup> |     | Anderson et al. <sup>19, 20</sup> |     | TOTAL |     |
|-----------------|-----------------------------|-------|------------------------------|-----|------------------------------|-----|-----------------------------------|-----|-------|-----|
|                 | No.                         | %     | No.                          | %   | No.                          | %   | No.                               | %   | No.   | %   |
| Gross Hematuria | 5                           | 1.3   | 3                            | 2.9 | 1                            | 0.8 | 2                                 | 0.8 | 11    | 1.2 |
| Loin Pain       | 4                           | 1.0   | 0                            | 0   | 2                            | 1.7 | 2                                 | 0.8 | 8     | 0.9 |
| Oliguria        | *(1)                        | (0.3) | 0                            | 0   | 1                            | 0.8 | 0                                 | 0   | 2     | 0.2 |
| Anuria          | 0                           | 0     | 0                            | 0   | 1                            | 0.8 | 1                                 | 0.4 | 2     | 0.2 |

\*Dowling<sup>15, 16</sup> defines 'renal calculi' as any of the above, but does not analyze these reactions.  
\*\*After massive intravenous dosage in a patient with subacute bacterial endocarditis.

ing 29 patients; a number manifested several types. Crystalluria and an occasional red blood cell were not considered urinary tract complications in agreement with Flippin<sup>9</sup>; crystalluria was present in 15 per cent of his cases. (Dowling's series of 428 patients<sup>15, 16</sup> is omitted from subsequent calculations because of inadequate detail.) Gross hematuria occurred in 1.2 per cent (11 of 897 patients); acute loin pain was present in 0.9 per cent (8 patients) and associated in each instance with other urinary signs; oliguria and anuria were reported in adults on two occasions (0.2 per cent), both apparently due to obstruction.

The patient with anuria mentioned by Hall

had her initial course of a sulfonamide as therapy for an acute bilateral otitis media. During a four-day period, she received a total of 10.5 gm. of sulfathiazole. Her temperature dropped to normal on the second day of treatment, and her urine was normal when examined on the fifth day.

Fifteen weeks later there was recurrence of the middle ear infection associated with an upper respiratory infection and a mild fever. The patient was treated symptomatically with little improvement for seven days, when sulfamerazine was prescribed. The initial dose was 1.5 gm.; thereafter, 0.5 gm. was given at six-hour intervals. Improvement was apparent after the second dose. A total of 4 gm. was ingested when nausea and vomiting began and the drug was immediately stopped. Fluid intake was adequate

up to this time. Within 36 hours after therapy was begun she passed only a few cc. of blood-tinged urine; analysis of this specimen showed numerous red blood cells, a few white cells, a trace of albumin, but no sulfamerazine crystals. Until her admission to the Children's Hospital (Columbus, Ohio) 36 hours later the patient was constantly nauseated and vomited all food and fluids. She attempted urination frequently, but was able to void at the most a few drops of gross blood.

Examination at time of admission to hospital revealed a dehydrated and somewhat toxic child; rectal temperature was 100°, pulse rate 100, and respirations 30 per minute. Both ear drums were slightly dull and not bulging. The tonsils were hypertrophied and the pharynx was slightly inflamed. Abdominal examination showed no tenderness or masses in the region of the kidneys and bladder. Laboratory findings included: R.B.C.—4.92 million with 12.7 gm. of hemoglobin, and a W.B.C. of 16,400 of which 83 per cent were neutrophils. No eosinophils were found. CO<sub>2</sub> combining power was 29 volumes per cent. Blood was not obtainable for non-protein nitrogen and sulfamerazine determinations.

Course in hospital: Immediately upon admission a hypodermoclysis of 2½ per cent glucose in physiologic saline was begun. A total of 2500 cc. was absorbed prior to the onset of urination 36 hours later. Anuria had lasted approximately 72 hours. The following day, there was excessive flow and incontinence of urine. Subsequent daily urinalyses until discharge revealed small amounts of albumin, but no crystals at any time. Five days after the inception of sulfamerazine therapy, there developed a generalized macular rash which was more prominent on face and arms. The rash persisted about 24 hours, disappearing with the return of temperature to normal. Further course was uneventful and the patient was discharged after 5 days with a negative urinalysis.

Examination four weeks later revealed the child to be in excellent health with normal blood count and urinalysis.

Discussion: This case is believed to be of particular significance because of the personal and family histories of allergy, the protean manifestations, and the occurrence of hematuria and a prolonged anuria with a persistent absence of sulfa crystals in the urine. The events may be likened to immediate and accelerated forms of serum disease<sup>2, 4</sup> in the following manner: Sensitization with the first period of sulfathiazole therapy; an interval of nearly four months following which a small amount of sulfamerazine produced a series of recognized hypersensitive reactions—nausea and vomiting, "drug fever", and dermatitis. The question of renal hypersensitivity will be discussed later.

#### CASE II

J.S., a 4 year old white female with a negative family and personal history for allergy, developed an acute left otitis media. Over a period of six days 11.0 gm. of sulfamerazine were given. On the fourth day of treatment the patient's temperature became normal; a urinalysis performed at this time was also normal. The dosage was reduced and continued for two more days.

After an interval of four weeks the child became ill with the measles, which was complicated by a recurrence of the middle ear infection. The left drum was incised and there was a profuse drainage of purulent material. Sulfamerazine

was again begun with 1.5 gm. as the first dose and 0.5 gm. every six hours. Anuria developed the following day after a total dosage of 3.5 gm. and the drug was stopped. Fluids were forced by mouth and urination began after an anuric interval of 24 hours. For the subsequent 24 hours urine was voided in small amounts, one-half to one ounce every few hours. One day later normal urination was resumed.

Laboratory examinations: Urinalyses performed on specimens obtained the day urination was resumed and the following day revealed a few red blood cells, occasional white cells, and no crystals. A complete blood count gave normal red count and hemoglobin, white blood cells were 13,800 with a differential count of 79 per cent polymorphonuclears and 21 per cent lymphocytes; eosinophils were absent.

Further course: A septic type of temperature continued for three weeks; mastoid surgery was considered in the middle of the febrile period.

Discussion: This case is thought to be of interest because of a possible hypersensitive type of reaction. Anuria was produced at the onset of a second course of sulfamerazine and throughout illness no overt evidence of crystalluria appeared. As in the previous case, this may be compared to an accelerated serum reaction—a sensitizing course of medication with antibody formation, a time interval, and a second administration of the drug acting as an antigen.

#### COMMENT

The urologic reactions to the sulfonamides have been considered in great majority to be upon the purely mechanical basis of blockage. To a large extent, this explanation can not be questioned; it appears, however, that the other causes of renal complications have not been sufficiently explored. Among the latter may be mentioned disturbances to the kidney parenchyma, whether they be of a toxic nature or allergic in origin.

Concrement obstruction may occur at any point in the urinary passages: Convolute tubules, renal pelves, ureters and ureteral orifices; and the literature is replete with reports of obstruction produced at all levels by sulfapyridine, sulfathiazole, and sulfadiazine. As mentioned previously only two cases of anuria in adults attributable to sulfamerazine have been noted in the literature. Anuria in children to any of the sulfonamides is a rare occurrence; Wilson and Billingsley<sup>22</sup> report it for 96 hours in a two year old patient as a result of complete obstruction to the lower portions of both ureters following sulfapyridine therapy; the concretions being dislodged by cystoscopy. Toxic reactions in general are found to be less frequent in children than in adults.<sup>18, 23</sup>

The effects, other than mechanical, of the sulfonamides upon renal tissue may be divided into: (1) Reactions due to the toxic nature of the drug, and, (2) those due to hypersensitivity phenomenon. This view has been emphasized by Murphy et al.,<sup>24</sup> and Hall and Spink,<sup>18</sup> who believe that factors other than precipitation of



crystals are of importance and doubt whether alkalinization of urine would be of much benefit under these circumstances. It is readily conceivable as Quick<sup>25</sup> states that the untoward action of the sulfonamide upon the kidney may be similar to that produced in the liver by cinchophen after sensitivity to that drug has occurred. Thus the kidney may be considered sensitized and, therefore, act as a shock organ involved in an allergic reaction.

Pathologic studies of the kidneys of sulfonamide treated patients in fatal anuria (none reported treated with sulfamerazine) with no evidence of obstruction<sup>24, 26</sup> have revealed: In all, varying degrees of tubular degeneration; in some, glomerular changes and/or interstitial tissue inflammation including eosinophilic infiltration.

Rich<sup>27, 28, 29</sup> has made some interesting observations which may well concern the hyper-sensitive state of the kidney as well as aid in our understanding of the pathogenesis of other untoward reactions following the administration of sulfonamides. He found that an acute widespread arteritis and periarteritis, affecting the smaller vessels of many organs including the kidneys and presenting the same pathologic picture as periarteritis nodosa, occurred in both serum disease and in the toxicity of sulfonamide therapy. He was able to reproduce the lesions noted in man by injecting a single large amount of horse serum into rabbits and killing them at the height of the reactions or at the height of the serum disease. The vascular lesions were therefore an expression of an allergic reaction to foreign serum in one instance and to sulfonamide drugs in the other.

In considering the cases presented one may only hypothesize as to the nature of the underlying renal pathology. Because of the evidence suggesting an allergic basis, it is probable that the anuria in these patients was due to hyper-sensitive reactions producing one or more of the following: Swelling and degeneration of the tubular epithelium, an angioneurotic edema of renal tissue with subsequent blockage, and the acute vascular changes as observed by Rich. A purely toxic action of the drug could readily produce the same clinical pictures, although it would be difficult to eliminate allergy as the dominant factor.

It is pertinent to emphasize that toxic reactions occurred in both cases on the second course of therapy. There may be, however, an anaphylactic type of reaction as observed by Salvin.<sup>30</sup> He reported an acute anaphylactic reaction characterized by sneezing, lacrimation, shortness of breath, urticaria and fever within 24 hours after the first dose of sulfanilamide. Here there was no sensitizing course of sulfonamide therapy. However, it is possible that an individual may become spontaneously sensitive

to one or more of the drugs of this group. Ratner<sup>2</sup> makes the interesting observations that sensitization may occur through previous administration of related chemical compounds such as procaine, or by passage of the drug through the placenta or breast milk.

Since the mode of sulfonamide excretion is urinary, it is logical to presume that a higher degree of sensitivity could develop in the urological tract because contact with the drug is maintained throughout the physiologic process of excretion; the drug may be present in a higher concentration than in the blood stream or other organs. Thus an individual with an allergic constitution may more readily develop a hyper-sensitive state from sulfonamide therapy and manifest untoward reactions to a small dosage of subsequent ingestion of the same or related compounds.

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# Capillary Fragility and Allied Tests

J. D. WALTERS, M.D.

THE capillary resistance test, variously referred to as the blood pressure cuff, constriction, fragility, petechial, and tourniquet tests, was used on 3,305 patients with dermatological problems. The pressure was maintained for five minutes at the diastolic level. Where the petechiae were fewer than 10, the reading was considered "negative"; between 10 and 20, they were termed "one plus"; between 20 and 30, "two plus"; 30 and 40, "three plus"; and above 40, "four plus".

Petechiae form when failure occurs in the mechanism of hemostasis. This condition may be due to any of three factors:<sup>1</sup> First, extravascular causes which may be due to tissue rigidity, disturbances in tension, or elasticity; second, vascular problems such as defects inherent in the blood vessels which may have poor collagen content; and third, intravascular factors concerned with delayed coagulability or defects in the contents of the blood clot.

These purpuric follicular and perifollicular dots appear below the level of the cuff. Although they occur chiefly in the ante-cubital area, the extension frequently may be seen down to the wrist, and occasionally encroaches on the dorsal surface of the forearm.

Of the series of 3,305 patients studied, 2,065 were female and 1,240 were male. Results showed "four plus" reactions in 827 cases, "three plus" in 513 cases, "two plus" in 465, "one plus" in 355, and "negative" in the remaining 1,145.

Definite susceptibility to petechial reactions were found in the following dermatological problems: Angioneurotic edema, capillaritis, dermatitis dietary deficiencies, dermatitis medicamentosa, erythema multiforme, erythema nodosum, granuloma annulare, hidradenitis suppurativa, nail dystrophies, pruritus genital areas, rosacea, varicose eczema, vitiligo, and xanthelasma.

Moderate and milder capillary fragility results were obtained in some of the more common cutaneous conditions such as: Acne vulgaris, alopecia areata, atopic dermatitis, contact dermatitis, dermatitis external ears, dermatitis eyelids, dermatitis herpetiformis, dermatomycosis, eczema, herpes zoster, ichthyosis, lichen planus, lupus erythematosus, occupational dermatitis, pityriasis rosea, poison ivy, psoriasis, recalcitrant vesicular eruptions (hands and feet), seborrheic dermatitis, sycosis vulgaris, syphilis, and urticaria.

A group of 423 cases showing capillary fragility were further studied for calcium, vitamin C, prothrombin and platelet levels. Tests for

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fibrinogen, anti-prothrombin, coagulation time, retraction of clot, and vitamin P were not done.

In these cases, normal, low and high levels of calcium, vitamin C, prothrombin and platelets were present. Patients having alopecia areata, numular eczema, herpes zoster, hidradenitis suppurativa, and rosacea should be studied for possible low calcium levels, as there seems to be a predisposition to hypocalcemia in the above-mentioned dermatoses.

Vitamin C levels seem to be low particularly in: Acne vulgaris, atopic dermatitis, generalized eczema, and varicose eczema.

Further investigation with regard to Vitamin C levels should be made in alopecia areatas, dietary deficiency states, erythema multiforme, herpes zoster, and hidradenitis.

The patients tested varied in age from five to 82 years. Although hypertension has been given as a predisposing cause, 371 of the 423 cases had blood pressures below 130 systolic and 80 diastolic.

The use of either Vitamins C or P has not solved the problem in increasing the resistance of the capillary wall in all cases. It is well known that lack of ascorbic acid will cause fragility of these skin vessels and in such cases, vitamin C has improved the condition. Others<sup>2</sup> state that vitamin P was used with success.

Vitamin C levels were above the normal of 0.7 ugs. per cent in 298 patients, and subnormal in the remaining 125.

Vitamin P was given to 24 patients who showed a positive constriction test and a normal plasma ascorbic acid content. Of these 24, only two showed favorable progress and had a negative petechial reaction after four weeks of fortification with vitamin P.

Of a group of 75 patients with negative capillary fragility tests, 60 patients (10 of whom had a history of gastric or duodenal ulcers) showed



low levels of Vitamin C, 8 had low platelet levels, 19 had hypocalcemia, and 17 had hypercalcemia. Prothrombin levels were normal in all 75 cases.

Brewer<sup>3</sup> found rhythmic changes in skin permeability that were associated with cyclic menstrual rhythm.

The resistance test was performed on 28 females just prior to their menses, and on 12 during the early phase of menstruation. Records were then studied in the same group at the intermenstrual phase. Due, perhaps, to the small number of patients studied, the results were inconclusive as to whether the capillary fragility was increased at the onset of the menses.

Beaser, Rudy and Seligin<sup>4</sup> find increased capillary fragility especially in the diabetics. Of the 3,305 patients studied, those having a rheumatoid, diabetic, rosacea, or varicose vein, eczema history are shown uniformly to have a poor capillary resistance. It is also interesting to note that many of these petechiae form very early in the test, some being evident after two minutes have elapsed.

In patients being afflicted with erythema multiforme, erythema nodosum and capillaritis, the petechiae produced by constriction tests were of the deepest purple and were of larger diameter than those seen in other dermatological conditions so tested. In the three diseases mentioned, the purpuric response was evident all the way down to the finger tips as well as on the dorsal surfaces of the hands.

In summarizing, capillary fragility is concerned with extravascular, vascular and intravascular factors. These factors are influenced by low and high levels of calcium, vitamin C, prothrombin and platelets as well as other undetermined causes.

A group of 15 dermatological conditions definitely show a tendency to formation of petechiae.

Hypocalcemia has occurred frequently in alopecia areata, numular eczema, herpes zoster, hidradenitis suppurativa, and rosacea.

Vitamin C levels were below normal in acne vulgaris, atopic dermatitis, generalized eczema, and varicose eczema.

When rechecks were taken after metabolism, diet, certain occupations, habits, and exhaustive states were corrected, negative fragility reactions invariably were found.

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## KEEPING UP WITH MEDICINE

SOME authors describe a relation between vitamin C and the hormones controlling sexual development and activity. Bonnin has been successful with stilbestrol-vitamin C sexual therapy in the treatment of the female climacterium in which stilbestrol alone was not satisfactory and suggests that it may be possible to stabilize the results obtained with stilbestrol-vitamin C therapy with vitamin C alone.

\* \* \*

LIKE the following from the editorial pages of *The New England Journal of Medicine and Surgery*, "Since the placental barrier is assumed to hold back cellular elements, since some persons respond to Rh antigen by anti-Rh production, since 49 per cent of Rh+ men are heterozygous and can father Rh-children, and since two or more pregnancies are usually necessary to produce infants suffering from erythroblastosis fetalis, this disease remains a fairly rare complication of Rh differences between mates. It may even be suggested that other incompatibilities between man and wife are more hazardous to married life than differences in the Rh factor."

\* \* \*

PSYCHOSOMATIC Medicine is an unfortunate term for it assumes that the body and the mind are not one. Its use should be discouraged.

\* \* \*

IT is difficult to influence the weight or the nutrition of the fetus as long as the mother is well nourished. Maternal deficiencies, however, may influence the fetus unfavorably.

\* \* \*

ONE of the interesting things about chemoprophylaxis is that with Sulfadiazine the sulpha drug does not produce sensitization.

\* \* \*

THE professors are finding out what every midwestern man has known all his life i. e., the fried potato, the flapjack, the doughnut, and the crisp egg are not only digestible but good for you.

\* \* \*

SO far as we know today, common sugars widely available in the dietary are equally valuable as sources of energy to the body. Any distinctions that can be drawn are too fine to be practical.

\* \* \*

IN so-called left heart failure the ability of the lungs to adapt themselves rapidly to the suddenly increasing circulation determines whether the picture will be one of acute pulmonary edema, subacute cardiac asthma, or chronic circulatory emphysema.

—J. F.

# Thrombosis of the Superior Mesenteric Artery

MAURICE E. GREEN, M.D., D. L. EYLER, M.D. and JOHN C. WEETER, M.D.\*

**Case 202093:** J.K., a 75 year old white male, was admitted to the surgical service of the Cincinnati General Hospital on the evening of April 6, 1945, complaining of severe abdominal pain of eight hours duration.

**History:** At 10:00 A.M. on the day of admission, while sitting in a chair, the patient was suddenly seized with epigastric pain of moderate severity. A few minutes later he became nauseated, vomited, and passed a liquid stool of normal color. The pain was continuous, but varied somewhat in intensity, and increased in severity until admission. He described the pain as being most marked in the epigastrium and the right upper quadrant; it radiated to the right flank and through to the midback. The patient took an aspirin tablet and a drink of whiskey without relief. During the day he experienced three more episodes of vomiting and passed one loose stool. No blood was noted in either the vomitus or the stool.

The patient stated that he had been feeling well prior to the onset of the present illness. On the night before admission he had drunk a few glasses of beer, and on the morning of admission he had eaten his usual breakfast of corn-flakes and graham crackers. The patient's daughter stated in a later interview that her father had always been well, but on the night before admission his family noticed that he did not look as well as usual, and that he complained of a dull aching pain in the right flank. Past history and review of systems were entirely negative for gastro-enteric and cardio-respiratory complaints.

**Physical Examination:** Temperature 97°; pulse 100; respirations 24. The patient was a well developed, somewhat obese elderly white male who complained bitterly of abdominal pain. He was very restless, and rolled about constantly. A perceptible difference was noted in the radial pulses, the left being stronger than the right. Blood pressure was 200/100 in the right arm and 250/110 in the left arm. The peripheral vessels were noted to be sclerotic. The skin was cool and dry, with some cyanotic mottling over the abdomen. A mild cyanosis of the lips and nail beds was present. Respirations were abdominal in character. The lung fields were clear to percussion and auscultation. The heart was slightly enlarged to the left; cardiac rhythm was regular, the tones were of good quality, and no murmurs were heard. The abdomen was slightly distended, and there was diffuse abdominal tenderness, most marked in the epigastrium, right upper and right lower quadrants. Some tenderness was elicited in the right costovertebral angle. On palpation there was splinting of the entire abdominal wall. No masses were felt. Peristaltic sounds were normal in character, with occasional loud gurgles heard. Rectal examination revealed no tenderness, and no masses were felt.

**Laboratory Data:** In Receiving Ward—WBC 15,800; urine showed 1+ albumin, no sugar, no acetone. Subsequent laboratory findings on the ward were—urine: 2+ sugar, 3+ acetone, microscopic examination negative; blood sugar—166 mgm. per cent; CO<sub>2</sub> combining power—45 volumes per cent; serum amylase—218 Bodansky units.

**X-ray:** Flat and erect roentgenograms of the abdomen revealed that scattered gas and scattered fluid levels were present. A definite obstructive pattern was not seen. The liver was not enlarged.

**Course:** The patient was given codeine, gr. 1, a clysis of normal saline solution, and Wangenstein suction was started. He soon became quieter and said that he felt better. Three hours later the pain had become more severe, distention had increased, and tenderness was now more generalized and more marked than on admission. A slight amount of rigidity of the entire right side of the abdomen was now noted, and peristalsis was not audible. Laboratory examinations revealed 14,750 WBC; urine showed 2+ sugar, 2+ acetone, and negative microscopic examination. Blood pressure was now 190/100 in the right arm and 220/100 in the left arm.

In view of the increased signs of peritoneal irritation, an intra-abdominal inflammatory lesion was suspected. During the short period of clinical observation the patient appeared to be rapidly getting worse, and an exploratory laparotomy was decided upon, the tentative diagnoses being: (1) Ruptured hollow viscus; (2) Possible acute cholecystitis with perforation; (3) Possible acute pancreatitis; (4) Possible intra-abdominal vascular accident, either mesenteric thrombosis or dissecting aneurysm of the abdominal aorta.

The patient was given the usual preoperative medication and taken to the operating room, at which time the routine check of the blood pressure revealed that it had fallen to 80/40. Pulse at this time was 110. The patient was given three units of plasma, one unit of whole blood, and oxygen by mask, but in spite of this therapy the blood pressure remained at 80/40 and his general condition became worse. The operation was cancelled and the patient was returned to the ward in a semicomatose condition.

Six hours later, the patient still appeared critically ill; he was cyanotic and complained bitterly of abdominal pain. Blood pressure at that time was 140/80 bilaterally; pulse was 110; respirations 30; and temperature 102.2°F. The abdomen was distended, diffusely tender, and moderate generalized rigidity was present. No peristalsis was heard. At this time the serum amylase was 452 Bodansky units. He was given morphine for pain. The following morning the patient's condition was extremely grave; he was comatose with respirations grunting and shallow despite the administration of oxygen. At this time the serum amylase was 248 Bodansky units; temperature 99.2°F; pulse 108; respirations 32 per minute. A few cc. of urine obtained by catheter were negative for sugar and acetone, and the patient had become oliguric despite continuous administration of intravenous fluids. The blood pressure gradually fell to 0/0, the pulse

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This is the twenty-third in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.



became imperceptible, and the patient finally ceased to breathe 44 hours after admission. Final diagnosis at the time of death were: (1) Acute pancreatitis; (2) Possible ruptured hollow viscus; (3) Possible intra-abdominal vascular accident.

#### CLINICAL-PATHOLOGICAL CONFERENCE DISCUSSION

Dr. Francis Woods: The sudden onset of abdominal pain with distention, epigastric and right sided tenderness followed by signs of peritoneal irritation, a rising serum amylase, and glycosuria would in my opinion make acute pancreatitis the most likely diagnosis. Acute cholecystitis with perforation of the gall bladder should be considered less likely. However in a patient of this age, I do not think mesenteric thrombosis can be ruled out.

Dr. Louis G. Herrmann: Were the dorsalis pedis pulses present? Answer: The dorsalis pedis pulses were not palpable but it was noted that the femoral pulses were equal.

Dr. Herrmann: Was there a history of pain in the back? Answer: The patient is said to have complained of low back pain the day before admission.

Dr. Herrmann: This patient's age, together with the evidence of advanced arteriosclerosis with hypertension and the history of pain in the back without physical signs of peritoneal irritation at the time of admission to the hospital, should make us think first of a retroperitoneal vascular accident. The precipitous drop in blood pressure, associated with abdominal distention without audible peristalsis, would make me think primarily of a dissecting aneurysm of the abdominal aorta near the origin of the renal arteries with irritation of the lumbar sympathetic ganglia and chains, resulting in paralytic ileus. Retroperitoneal hemorrhage from such a source usually gives signs and symptoms which are quite similar to those produced in intra-abdominal inflammation. The absence of the pulses in the pedal arteries in this patient is further evidence of peripheral arteriosclerosis, and the presence of pulses in both femoral arteries would not, in itself, rule out the presence of a dissecting aneurysm of the abdominal aorta.

I would conclude that this patient's symptoms and signs were the result of retroperitoneal bleeding from an arteriosclerotic aneurysm of the aorta.

Dr. M. M. Zininger: The history of pain in the back, high serum amylase, glycosuria and the presence of epigastric and right sided tenderness with pain radiating to the back are in favor of acute pancreatitis. However, the absence of peritoneal signs on admission is against this diagnosis. A vascular accident with retroperitoneal hemorrhage is very likely. Mesenteric thrombosis can not be ruled out. I have recently seen a patient with very similar story and findings in

whom the diagnosis at autopsy was mesenteric thrombosis.

Dr. E. McGrath: Which do you think most likely?

Dr. Zininger: In my opinion the most likely diagnosis is a vascular accident with retroperitoneal hemorrhage. My second and third choices would be acute pancreatitis and mesenteric thrombosis.

Dr. Edwin P. Lehman: I agree with Dr. Herrmann and think the story and findings are those of retroperitoneal hemorrhage.

Dr. W. A. Altemeier: I do not see how you can rule out a diagnosis of mesenteric thrombosis. There are two distinct forms of mesenteric thrombosis, arterial and venous, and each presents a different clinical picture. In arterial thrombosis, the symptoms and signs have a sudden onset, are severe and show a rapid progression. In venous thrombosis the symptoms and signs are less severe and their development and progression are often comparatively slow. It may take three or four days for a case of venous thrombosis to reach the same stage which one of arterial thrombosis will reach in twelve to eighteen hours.

In the case which has been presented today, I believe the pertinent points to be considered are: (1) The presence of known arterio-vascular disease; (2) The development of abdominal pain, of sudden onset, and moderate severity. This pain increased in severity and was associated with nausea, vomiting and liquid stools; (3) Absence of signs of peritoneal irritation in the first few hours of the illness; (4) The development within approximately eight to ten hours of signs of peritoneal irritation; (5) The rapid and sudden appearance of vasomotor collapse approximately twelve hours after the onset of abdominal pain. This collapse could be interpreted as being caused by absorption of split-protein products from the wall of the bowel which had become gangrenous. Although there was no hematemesis, or blood in the stools, I believe acute mesenteric thrombosis of the arterial type with infarction and gangrene of the intestinal wall the most probable cause for this patient's clinical picture.

**Necropsy (N-45-160):** The examination was performed 2 hours postmortem. The abdominal cavity contained a small quantity of fluid which was pinkish-yellow and slightly cloudy. Marked reddish-black discoloration of the inner surface of the anterior and lateral abdominal walls was present, but no frank exudate was noted on the slightly dulled peritoneal lining. The entire jejunum and ileum were distended and appeared gangrenous from a point approximately 10 cm. beyond the duodenojejunal flexure to a point 15 cm. from the ileocecal junction. The wall of the jejunum and ileum was edematous and brownish-black; the lumen contained dark brown semi-solid feces. No point of perforation was noted. The mesentery appeared edematous and dissection of the superior mesenteric artery revealed



the presence of a pink thrombotic embolus impacted in the artery at the base of the mesentery.

The heart weighed 500 grams, and all the chambers were slightly dilated. The wall of the left ventricle was slightly increased in thickness. Sections of the myocardium revealed an area of infarction which included the apex of the left ventricle and the lowermost portion of the interventricular septum, in the general area supplied by the anterior descending branch of the left coronary artery. The infarcted tissue was moderately firm and pale, but not yet tough and fibrous. A few scattered areas of tough fibrous tissue were noted elsewhere in the myocardium of the left ventricle. Firmly attached to the endocardium at the apex of the left ventricle was a well organized mural thrombus, which appeared fleshy and pink, and was similar in consistency and color to the embolus found in the superior mesenteric artery. The coronary arteries exhibited a moderate number of slightly elevated yellow atheromatous plaques, and at a point two-thirds of the distance down the septum, the anterior descending branch of the left coronary artery exhibited marked narrowing, and finally gross obliteration of the lumen. The valves were normal. No other pathologic changes were noted except for congestion of the other viscera.

**Microscopic Examination:** Sections of the myocardium revealed an area of infarction, adjacent to which was attached a portion of endocardial mural thrombus. This thrombus was well organized, showing numerous small blood vessels infiltrating the mass, together with a moderate number of fibroblasts. In addition, several areas of focal myocardial fibrosis which appeared to be old small infarcts were seen in the left ventricle. The coronary arteries showed marked atherosclerosis, and the smaller branches near the apex were completely occluded. The superior mesenteric artery showed an organized thrombotic embolus impacted within the lumen, consisting of tissue similar in appearance to that of the endocardial mural thrombus. The small intestine revealed complete loss of nuclear structure in the ghost-like cells of its entire wall. The kidney exhibited vascular sclerosis, with focal areas of interstitial fibrosis and hyalinized glomeruli. The remaining viscera showed congestion, active chronic inflammation around the intrahepatic bile ducts, and slight chronic inflammation of the prostate with benign glandular hyperplasia.

**Final Pathologic Diagnoses:** Embolic occlusion of the superior mesenteric artery, with infarction of the jejunum and ileum; coronary artery sclerosis with recent myocardial infarction and organizing mural thrombus; cardiac hypertrophy and slight dilatation; acute and slight chronic passive congestion of the abdominal viscera; arteriolonephrosclerosis.

### Nicotine

The effect of nicotine on the sensitized or diseased peripheral vascular bed is so deleterious that nobody can effectively treat peripheral vascular disease unless smoking has been completely and permanently stopped. This is more easily said than done. It is true that the younger patient with thromboangiitis obliterans will respond more intensively to nicotine than the elderly arteriosclerotic.

### The Vasomotor Apparatus

The vascular tree is not a set of rigid tubes, but a pulsating, elastic system, whose muscles can contract in response to direct trauma or to cold but which are also governed by the autonomic nervous system, which is predominantly vasoconstrictor. Stimuli, which affect the vasoconstrictors, include central, emotional stimuli, or reflex stimuli due to pain, heat or cold, food, and many other factors. But from a practical standpoint three outstanding stimuli dominate the vasoconstrictor apparatus, namely cold, posture and nicotine.

Sympathetic vasoconstriction is completely abolished at 85° Fahrenheit, but any temperature below this will maintain a certain tonus. For this reason, in our climate, fluctuations of vasomotor tonus do effect the vascular tree and it is well known to all vascular clinics that the number of patients greatly increase with the advent of chilly weather. This does not mean, however, that 85° Fahrenheit is the optimal temperature for all patients suffering from peripheral vascular disease, since it may be too high for a patient with a severe vascular occlusion whose leg would be painless and safer at 70° Fahrenheit. A warm footbath followed by a woollen sock or a flannel boot over the affected extremity is the best protection against dissipation of heat without use of too much heat or too much cold. The idea of chilling or refrigerating an ischemic extremity is fraught with considerable danger, unless one has decided on an amputation. It is true that pain is effectively relieved, but if one expects to save an extremity refrigeration will only add the syndrome of an immersion limb of the shipwrecked sailors to the pre-existing vascular disease. It is a practice to be condemned unless it is used to eliminate pain and absorption from a *lost* extremity. Even then, I prefer to amputate under spinal or sodium pentothal anesthesia, since the healing of the stump is retarded by refrigeration.<sup>19</sup>

The effect of posture on vasomotor tonus has been much less often discussed. It is clear, however, that in man, the erect animal, vasoconstriction is marked during standing, especially in the lower extremities; only so can man maintain his blood pressure in the erect position. If one takes blood pressures with a self-registering apparatus in the standing position one is amazed at the hypertension which prevails in the lower extremities of a normal individual.—Geza De Takats, M. D., Chicago; The Jr of the Mich. State Med. Soc., Vol. 44, No. 5, May, 1945



# Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

**R** EPORTS from American clinicians made over a period of years indicate that tuberculosis occurs four times as frequently in diabetic persons as in the general population. The age of the diabetic patient is important. One study in Massachusetts showed that tuberculosis was more than 13 times as frequent among those who acquired diabetes before the age of 15 as it was among a corresponding group of school children, while among adolescent diabetic patients the incidence was 16 times as great as in a corresponding high school group.

Several theories have been proposed to account for the predisposition of diabetic persons to tuberculosis. Of these the one which the evidence seems to favor is that Vitamin A deficiency plays a part. Since a Vitamin A deficiency usually occurs in the presence of diabetes, this lack may explain in a large measure the increased susceptibility of diabetic patients to tuberculosis. Lack of Vitamin A causes specific pathologic changes in the mucosa of the respiratory system which favor the invasion of bacteria into the lung and bronchial tissues.

A wide discrepancy exists between the estimated number of cases of diabetes associated with tuberculosis and the number of such patients who are admitted to tuberculosis hospitals. Failure to hospitalize these patients in specialized institutions carries serious implications relating to the welfare of the patient and to the public health. The reasons for this failure may be (1) lack of diagnostic consciousness, (2) improper interpretation of symptoms, (3) incomplete diagnostic investigation, (4) asymptomatic forms of pulmonary tuberculosis. The higher recovery rate of persons with early tuberculosis as compared to those with advanced tuberculosis justifies a plea for an early diagnosis of this condition in diabetic patients.

Experience has shown that the best attitude is to anticipate the possibility of tuberculosis as a complication. A tuberculin test should be given to all persons with diabetes. This test should be repeated annually as long as it is negative. For those who react positively to tuberculin there should be a chest roentgenogram every year at least. Examination of the sputum should be carried out for all patients with a productive cough and if the roentgenogram of the chest indicates reason for suspicion, fasting stomach contents should be aspirated five successive times and examined by culture or by the inoculation of guinea pigs.

The percentage of diabetic patients entering the tuberculosis hospitals with minimal tuber-

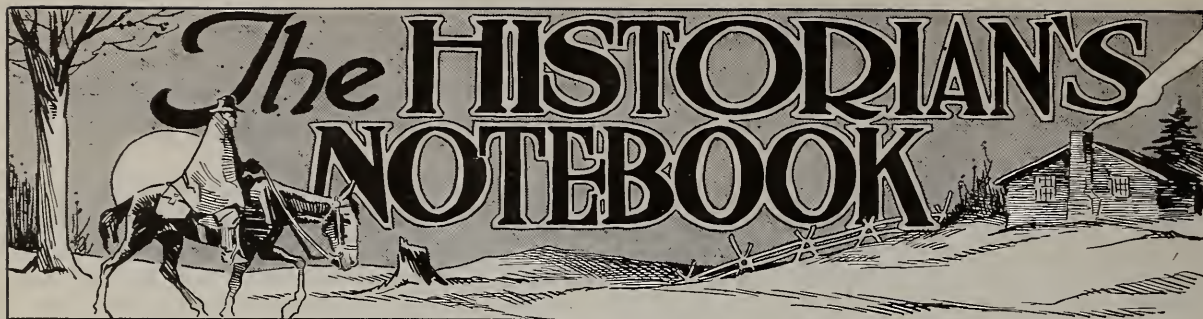
culosis seems to be unduly low and may be attributed to a lack of diagnostic suspicion on the part of the physician treating the diabetes. The emphasis formerly placed on the lack of subjective symptoms of diabetic patients with active pulmonary tuberculosis is no longer valid since mass X-ray surveys have revealed that asymptomatic tuberculosis also exists among nondiabetics. Several authors have observed that cavitation is frequent when pulmonary tuberculosis is complicated by the presence of diabetes. Other complications except that of spontaneous pneumothorax occur less frequently than they do in nondiabetic patients with tuberculosis.

The management of diabetes in the presence of tuberculosis has evolved with the trend in diabetic treatment. In the authors' experience it was found that in patients, who were given a well planned diet and adequate amounts of insulin, slight glycosuria and hyperglycemia not exceeding 200 mg. per hundred cubic centimeters are compatible with favorable therapeutic response as far as pulmonary tuberculosis is concerned. Improvement in the pulmonary condition of patients belonging to this group compares favorably with that recorded for tuberculous patients whose blood sugar was kept on a practically normal level.

Although it may appear heretical in the treatment of tuberculosis the authors are of the opinion that reducing the diet for overweight diabetic patients with pulmonary tuberculosis is as justifiable and practicable as for nontuberculous obese persons with diabetes. The administration of massive doses of Vitamin A from 150 thousand to 200 thousand U.S.P. units daily may serve as a useful adjunct in the management of diabetes mellitus complicated by pulmonary tuberculosis.

The indications and contraindications for collapse therapy are the same for diabetic as for nondiabetic tuberculous patients. Because of the frequency with which empyema complicates artificial pneumothorax in persons with predominantly exudative and caseous tuberculous lesions of recent origin, the use of this measure is rather limited for tuberculous diabetic patients.

An analysis of the reports of ten American clinicians based on the observations of 17,358 cases of diabetes indicates a higher incidence of tuberculosis in diabetic persons than in the general population of the United States.—Diabetes and Tuberculosis (with a review of the literature), Andrew L. Banyai, M.D., and Anthony V. Cadden, M.D., Archives of Internal Medicine, December, 1944.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## The Disappearance of Malaria in the Territory North of the Ohio

A BOOK REVIEW BY JONATHAN FORMAN, B.A., M.D.

MALARIA has been for centuries a disease of great importance. It has dramatically slain the great and the mighty. It has been cited as one of the causes of the destruction of one civilization after another. And still "from the standpoint of prevalence malaria appears to be the most important disease in the world today". It is estimated by competent authority that there are 300 million cases in the world and the number of deaths is set by the same experts at 3 million each year. Other estimates are all higher so these figures must be conservative. The most conservative figures on our own country are one million cases and five thousand deaths annually. The yearly economic losses are of the order of \$500,000,000.00 and the direct cost of sickness as much as \$51,000,000.00.

### PRIMARY PROBLEM

Malaria is our number one medical problem in this war and its victims may provoke a new wave of the disease throughout our land. The weight of the evidence seems to support the idea that the disease was brought onto this continent by the white man. Just how far back in history the disease could be found in the Ohio Country is not clear. But when the early settlers moved in of all his ills ague was the most common. So nearly inescapable, says Pickard and Buley, "that many refused to regard it as a disease, but considered it, like hard work, a concomitant of the frontier. There were different kinds of ague. Work schedules had to be made to fit the brand that one had. Justice arranged the docket to avoid the sick day of the litigants; the minister made his appointments in keeping with his own shakes; the housewife hurried through her morning chores, then sat down to wait her

visit of the fits; and even the sparking swain reckoned the ague schedule of himself and his intended."

One of the mysteries of medicine is why malaria disappeared. After having been once very prevalent, it disappeared spontaneously long before the introduction of systematic anti-malarial measures. Here in Ohio and the other Northern states the decrease came about quite independently of any conscious effort on the part of the various health agencies. But malaria has disappeared before in other times and in other countries only to come back. Rome rid itself of malaria three times between 200 B.C. and 1500 A.D. The mystery needs study from every angle and it is fitting that in our renewed interest in malaria here in the North, we should have given us an excellent historical account of the disappearance of malaria in a monograph by Dr. Erwin H. Ackerknecht (*Malaria in the Upper Mississippi Valley, 1760-1790, The Johns Hopkins Press, 1945, \$2.00*). The study is limited to the Upper Mississippi Valley States: Illinois, Missouri, Iowa, Wisconsin, and Minnesota, but the facts would seem applicable to Ohio as well.

### WHAT ARE THE FACTORS?

The author makes a study of each of the possible factors having a part in the disappearance of malaria from this region. There are some fourteen or more of these. His conclusions are summarized as follows:

"The arrest of populations movements was of considerable importance generally, and that even on the basis of very crude statistics relations can be established between a sudden drop in population increase and the decline of malaria for Missouri, Iowa, and Wisconsin. In so far



as the shift of settlements from watercourses inland, symbolized by the installation of railroads, is concerned the data of malaria decline and railroad building show such close coordination for all states that the importance of this factor can hardly be doubted."

Most of us are inclined to think that the drainage of the land was a measure of the greatest importance but Doctor Ackerknecht's studies on this point are inconclusive. It is not so easy as it appears. But it could not have been as big a factor as we had thought for the operation of organized drainage enterprises occurred so late that in Iowa, Wisconsin, and Minnesota not only the decline but the disappearance of malaria had preceded it. In Illinois and Missouri also, malaria decline antedated by decades organized drainage enterprises which nevertheless may have contributed to the speeding up of the process of disappearance, particularly in Illinois.

There is also a definite correlation between better housing and malaria decline in all states examined. Screening, however, occurred so late that it probably did not play much of a part, although the data is so scant that one can not be sure.

The discovery of the fact that many *anopheles* species, when faced with the opportunity to feed on man or on domestic animals, especially cattle, prefer the latter has solved many riddles of malariology. So here the influence of the increase in dairy cattle on the decline of malaria stands out as one of the important factors.

The author then attempts to find the part that quinine played. His conclusions are most interesting and surprising to most.

#### THE RIGHT ANSWER

"The right answer is not found in assumed but non-existent merits of quinine. Quinine does not avoid infection; quinine does not sterilize the carrier. Quinine, therefore, can not have a direct effect on the eradication of malaria from a community. Whoever tries to link quinine directly with the disappearance of malaria because quinine is the most direct anti-malarial measure, is pleading a lost cause, because he is pleading against the evidence. But quinine does have one quality which nobody denies and which may be decisive in certain historical situations: it stops the clinical attack, it makes people fit to fight and work, when without quinine they would not be able to do so."

So while the eradication of malaria in the North was to a large extent the indirect result of better agricultural methods, cattle breeding, better housing, screening, and education, quinine did have a role. It kept the settlers working and fighting through a decisive period. Quinine did break the vicious circle of disease-producing

inactivity and the inactivity conserving the sources of the disease. It made possible the indirect, unconscious socio-economic achievements. Without quinine the economic development of the whole region and therewith the decline of malaria would have been at least considerably retarded.

Malaria is always closely associated with a number of climatic conditions. In the latitudes of the Upper Mississippi Valley the part of the year during which all of the climatic conditions necessary for the *anopheles* and its young to grow, to live, and to be active was relatively very short. In addition to retarding the mosquito population, the long winters afforded a respite from the disease and so permitted the annual recuperation of the people.

Many historians would have us believe that malaria makes history instead of history making malaria. Not that other cultures did not become more malarious because of their decline, but rather that they declined because they became malarious; and that malarious countries could neither progress nor develop. That was just what was predicted for the Upper Mississippi Valley which went on to prove that even a highly malarious region might march forward towards progress unimpeded by malaria.

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#### Cancer Society Names New Director

New Acting Managing Director of the American Cancer Society is Admiral Charles S. Stephenson, U.S.N. (Retired), appointed by the National Executive Committee, to succeed Dr. Clarence Cook Little. Dr. Little, who has directed the Roscoe B. Jackson Memorial Laboratory at Bar Harbor, Maine since 1929, received a grant of \$282,000 from the Rockefeller Foundation for genetic and environment studies to be conducted at the laboratory which will take his full time. In addition, the biological research on cancer and allied conditions, the primary work of the laboratory, will be continued under Dr. Little's direction. He will remain a member of the Board of Directors of the American Cancer Society.

Admiral Stephenson, whose specialty is preventive medicine, is known for his work in cholera, plague and applied physiology and his achievements as director of the Department of Hygiene and Preventive Medicine of the United States Naval Medical School. He was advisory councilor of the United States Public Health Service and of the Division of Health and Safety of the Tennessee Valley Authority. He directed the United States of America Typhus Commission and was Liaison Officer of the Division of Medical Sciences of the National Research Council. He joined the Executive Staff of the American Cancer Society some months ago to direct the work of its Research Division.

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# A.M.A. Activities:

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Digest of News on the Current Projects,  
Programs and Services Which Are Being  
Carried on by Your National Society

THE Council on Physical Medicine of the American Medical Association has issued a detailed report on the question of diathermy and radio interference in which it supported the Federal Communications Commission in making frequency allocations which would eliminate to a large extent radio interference by diathermy equipment. The conclusions of the Council should be of interest to all physicians using diathermy equipment. The report was published on pages 362-363 of the June 2, 1945, issue of *The Journal of the A.M.A.*

\* \* \*

At a recent meeting the Council on Medical Service and Public Relations of the A.M.A. considered a long docket of important questions including: Medical service plans and medical indemnity programs; appointment of consulting committee for insurance companies; pending national legislation; supply of medical students; recommendation for A.M.A. committee on chronic diseases; cooperation with American Cancer Society; suggestion for state society information service on hospital building program. Complete details of the meeting will be found on pages 373-374 of the June 2, 1945, issue of *The Journal of the A.M.A.*

\* \* \*

At a recent meeting The Council on Physical Medicine transacted the following business: Received a report on methods commonly used in artificial respiration, prepared by Dr. Bernard Ross after a five-year study; named a group of consultants on occupational therapy; decided to revise the film on occupational therapy; received progress reports of special consultants on audiometers and hearing aids and of consultants on ophthalmic devices; voted to appoint consultants on electroencephalography; decided to furnish the booklet "Apparatus Accepted" to junior medical students; approved loan of slides on physical therapeutic subjects for teaching and lecturing purposes; discussed responsibility of medical schools in this field; affirmed its decision against approval of advertising using the term "sunshine vitamin" when referring to Vitamin D.

\* \* \*

The Council of Pharmacy and Chemistry of the A.M.A. has authorized the publication (June 16 issue of *The Journal of the A.M.A.*) of a statement on the status of cosmetics containing hormones which contained the conclusion that there is no excuse for the widespread use of hormone-containing cosmetics.

\* \* \*

An important meeting of the Committee on Postwar Medical Service was held on May 12. Among questions considered and action taken were the following: Received supplemental reports on questionnaire to medical officers, dealing with economics, and educational opportunities for returning medical officers; discussed operation of Bureau of Information; received report on apparent failure of Ellender Bill to provide Selective Service exemption for certain number of premedical and medical students; discussed question of sale of surplus medical and hospital supplies; analyzed the situation with respect to the Veterans Administration, and adopted statement opposing assignment of medical officers to veterans hospitals; discussed matter of release of essential medical teachers from the Army; received lengthy report on educational features of G. I. Bill following conference with officials of Veterans Administration.

\* \* \*

Through a series of bulletins to officials of state medical societies, the Council on Medical Service and Public Relations is supplying very useful information on major activities of the various state societies. This service provides the state societies with ideas and suggestions on new activities which might be undertaken. Some especially helpful data has been supplied by the Council on progress being made in some of the states with respect to voluntary prepayment medical care plans under the direction of the medical profession.



## Many Physicians Express Desire To Subscribe for Stock of Ohio Medical Indemnity, Inc.; Sale of Shares Will Be Started As Soon As Final Legal Details Are Completed

A CONSIDERABLE number of physicians who read the article in the June issue of The Journal, pages 541-544, relative to the incorporation of Ohio Medical Indemnity, Inc., by officials of the Ohio State Medical Association, have written to the Headquarters Office of the State Association, Columbus, expressing a desire to subscribe for one or more shares of the 5% preferred stock costing \$50.00 per share which will be offered to members of the medical profession.

The incorporators (officials of the Ohio State Medical Association) had hoped by this time to have subscription blanks in the hands of all members of the Association and the sale of the stock well under way. However, completion of final legal details with the Superintendent of Insurance with respect to qualifying stock for sale and the method of sale has required more time than had been anticipated. Such details are now being completed and it is anticipated that actual sale of stock can be started within the next week.

Physicians who desire to give financial support to the organization of the company by investing in the preferred stock may make known their intentions at this time by sending a letter to the Columbus office of the State Association. When the books for the sale of stock are opened, such physicians will be mailed official subscription blanks and their subscriptions will be filled in the order the letters were received.

As soon as the books for the sale of stock have been opened, all members of the Association will be sent a communication, requesting them to subscribe for stock, accompanied by official subscription forms. Subscriptions will be filled in the order they are received.

Officials of the Association are gratified over the interest and enthusiasm which has been shown to date by physicians in all parts of the state in the organization of the indemnity company. A substantial part of the 2,000 shares has already been spoken for by those who have read the June issue of The Journal, even though no direct communication has as yet been sent to individual physicians. For this reason, those who are especially anxious to own some of the stock of Ohio Medical Indemnity, Inc., and have a voice in its management, should make known their desires by writing the Columbus office at once.

As outlined in the June issue of The Journal, the purposes of the company, which will be a stock company organized under the Ohio Insurance Laws, are to provide indemnity against medical and surgical expenses by making cash payments to subscribers for surgery, fractures, dislocations and obstetrics in the hospital, fractures, tonsillectomies and adenoidectomies outside the hospital, and obstetrics in the home, under a definite schedule of benefits for such services. There will be a close working relationship between Ohio Medical Indemnity, Inc., and most of the Blue Cross Plans of Ohio on administrative details, sale of contracts, enrollment of subscribers, etc.

Watch your mail for a communication direct from the incorporators of Ohio Medical Indemnity, Inc., explaining how stock may be purchased and describing how the company will operate!

# Detailed Analysis of the New Wagner Sickness Insurance Bill, S. 1050, Recently Introduced in the Congress

INFORMATION available at this time indicates that hearings on the new Wagner-Murray-Dingell Bill, S. 1050, will not be held for some time—possibly not before Fall or early in 1946.

The new Wagner Bill, introduced in the Congress on May 24 by Senator Wagner of New York, is a document of 185 pages, covering every phase of compulsory social insurance, including a section to provide for a National Medical and Health Program.

Doubtless because of the length and importance of the proposal, Congress will not be inclined to rush hearings on it. In fact Senator Wagner himself has stated that he wants local medical groups to have plenty of time to study and analyze it. Moreover, Congressional leaders have indicated they desire to dispose of vital legislation on the war and international affairs before taking up domestic questions, one of which is possible modification of the Social Security Act.

Nevertheless, members of the medical profession should be preparing themselves for the impending battle on this measure. There are two things which each physician should do at once:

1. Write to his Congressman or to Senator Taft or Senator Burton, requesting a copy of S. 1050.
2. Read the appended analysis of the bill republished from *The Journal of the American Medical Association*.

Comments on the bill and on developments will be carried from time to time in *The Ohio State Medical Journal* and in *The Journal of the A.M.A.*

Following is the analysis of the proposal made by the Bureau of Legal Medicine and Legislation of the A.M.A.:

The 1945 Wagner-Murray-Dingell bill, S. 1050, differs in many respects from the previous one, some of which differences will be italicized or otherwise referred to in this and succeeding analyses. For one thing, it contains ninety-five more pages. Briefly and in broad outline, here is what the bill contains: It adds a new title to the Public Health Service Act for grants and loans for hospitals and health center construction. This title corresponds closely with the provisions of the Hill-Burton hospital construction bill, with significant exceptions. It provides for grants and services to develop more effective measures for the prevention, treatment and control of venereal diseases and tuberculosis and to extend and improve public health work. It proposes grants to states for maternal and child health services, for services for crippled children and for child welfare services. It would make available grants

to states for public assistance to needy individuals, including medical care for such individuals. Section 9 proposes to amend title II of the Social Security Act to provide a national social insurance system. The amended title would provide for (a) prepaid personal health service, (b) a national system of unemployment and temporary disability insurance (including cash benefits for disability from sickness which causes unemployment), (c) retirement, survivor and extended disability benefits, (d) a national social insurance trust fund, (e) credit for military service, (f) extended coverage to include an estimated additional 15,000,000 persons, (g) contributions or taxes by employers, employees and the self-employed and (h) certain general provisions to apply to the operation of the title.

## DIVISION OF CONTRIBUTIONS

| Program                                                      | Employer | Employee | Total |
|--------------------------------------------------------------|----------|----------|-------|
| 1. Retirement, survivors and extended disability insurance.. | 1.0%     | 1.0%     | 2.0%  |
| 2. Medical care and hospitalization insurance .....          | 1.5%     | 1.5%     | 3.0%  |
| 3. Unemployment insurance ....                               | 1.0%     | 1.0%     | 2.0%  |
| 4. Temporary disability insurance                            | 0.5%     | 0.5%     | 1.0%  |
| Total contributions .....                                    | 4.0%     | 4.0%     | 8.0%  |

Some of the foregoing parts of the bill will be dealt with in subsequent analyses. The present analysis will be confined to that section of the bill proposing a system of compulsory health insurance to be "made available to 135,000,000 persons", in the words of Senator Wagner. In passing, it is perhaps significant to note that the term "compulsory" appears in no place in the releases made available by Senator Wagner to explain the contents of his bill and to construe its provisions. Rather the emphasis has been placed in such releases on the contention that the legislation will not interfere with the normal relationship between the patient and his physician and on the point of view that the health insurance provisions will not be mandatory on the medical profession.

The national social insurance system will be financed in general from a trust fund established by a 4 per cent employer and a 4 per cent employee contribution on wages and salaries up to the first \$3,600 a year paid or received after Dec. 31, 1945. The first bill placed the ceiling at \$3,000 a year and the employer-employee contribution at 6 per cent each. The contribution to be made by the self-employed will be 5 per cent of the market value of the services subject to the same ceiling limitation. The contribution by states and localities and by their employees will be 2.5 per cent of the first \$3,600. The contributions that employers and employees will make to finance the system will be distributed as shown in the table.

## MEDICAL, HOSPITALIZATION, DENTAL, NURSING AND RELATED BENEFITS IN GENERAL

Part A of the amended title II proposes a system of compulsory prepaid personal health service insurance to covered employees and certain specified dependents. As used in this part, the



term "personal health service benefits" is defined to include general medical benefits, special medical benefits, general dental benefits, special dental benefits, home nursing benefits, laboratory benefits and hospitalization benefits. There was no provision in the first bill for dental or home nursing benefits. When the term "general medical benefit" is used it means services furnished by a legally qualified physician or by a group of such physicians, including all necessary services such as can be furnished by a physician engaged in a general or family practice of medicine, at the office, home, hospital or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic examination. The definition in the earlier bill did not refer to services rendered "by a group of such physicians".

The term "special medical benefit" is defined as necessary services requiring special skill or experience, furnished at the office, home, hospital or elsewhere by a legally qualified physician who is a specialist or consultant with respect to the class of service furnished, or by a group of such physicians, or by a group of physicians including such specialists or consultants.

The term "general dental benefit" is defined to mean services furnished by a legally qualified dentist or by a group of such dentists, including all necessary dental services such as can be furnished by dentists engaged in the general practice of dentistry, with or without the aid of an assistant or hygienist under his direction, and including preventive, diagnostic and therapeutic treatment, care and advice, and periodic examinations. Similarly, the term "special dental benefit" is defined to mean necessary services requiring special skill or experience, furnished at the office, hospital or elsewhere by legally qualified dentists (with or without the aid of an assistant, hygienist or anesthetist under his direction) who is a specialist or consultant with respect to the class of service "furnished by a group of such dentists, or by a group of dentists, including such specialists or consultants".

"Home nursing benefit" means nursing care of the sick furnished in the home by (1) a registered professional nurse or (2) a practical nurse who is legally qualified by a state or, in the absence of state standards or requirements, who is qualified with respect to standards established by the Surgeon General after consultation with the Advisory Council and with competent professional nursing agencies and who furnishes nursing care under the direction or supervision of the state health agency, the health agency of a political subdivision of a state or an organization supplying and supervising the services of registered professional nurses.

A beneficiary entitled to laboratory benefits will receive such necessary laboratory or related services, supplies or commodities as the Surgeon General may determine, including chemical, bacteriologic, pathologic, diagnostic and therapeutic X-ray and related laboratory services, *refractions and other ophthalmic services furnished by a legally qualified practitioner other than a physician*, physical therapy, special appliances prescribed by a physician, and eyeglasses prescribed by a physician or other legalized practitioner. If any of the services, supplies or commodities covered by this definition are provided a hospitalized patient, or by a physician or dentist incidental to services rendered, payment therefor will be included in payments for hospitalization or for services furnished, respectively.

"Hospital benefit" is defined to mean an amount as determined by the Surgeon General after consultation with the Advisory Council created by the bill (S. 1161 required the determination to be made "after approval by Social Security Board"): not less than \$3 and not more than \$7 (\$6 in the first bill) for each day of hospitalization not in excess of thirty days in a period of hospitalization, not less than \$1.50 and not more than \$4.50 (\$4 in the first bill) for each day of hospitalization in excess of thirty in a period of hospitalization, and not less than \$1.50 and not more than \$3.50 (\$3 in the first bill) for each day of care in an institution for the care of the "chronic sick". In lieu of such compensation, the Surgeon General may enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates previously mentioned. In S. 1161 such contracts were conditioned on the approval of the Social Security Board.

A new provision relating to these contracts with participating hospitals provides that payment may be included in a contract for inclusive services of a participating hospital and its staff or attending staff and that such payment will not affect the right of participating hospitals to require payments from patients with respect to the additional cost of more expensive facilities furnished for lack of ward facilities or occupied at the request of the patient, or with respect to services not included within a contract.

A hospital may become a "participating hospital" if it is an institution which provides all necessary and customary hospital services and is found by the Surgeon General to afford professional service, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institutions. The Surgeon General may accredit a hospital for a limited variety of cases and may accredit an institution for the care of the "chronic sick", taking into account, for the purpose of such limited accrediting the type and size of the community which the institution serves, the availability of other hospital facilities and such other matters as the Surgeon General may deem relevant.

#### NATIONAL ADVISORY MEDICAL POLICY COUNCIL

The pending bill contemplates the creation of a National Advisory Medical Policy Council. This Council will consist of the Surgeon General as chairman and sixteen members appointed by him *without regard to the Civil Service laws and subject to the approval of the Federal Security Administrator*. The appointed members will be selected from panels of names submitted by professional and other agencies and organizations concerned with medical, dental and nursing services and education and with the operation of hospitals and laboratories and from among other persons, agencies or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory or related services and benefits. A new provision in the bill requires the membership of the Advisory Council to include (1) medical and professional representatives and (2) public representatives in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services, having regard for the functions of the Advisory Council.

Appointed members will hold office for four



years, with terms of office staggered, and will receive compensation at the rate of \$25 a day for the time spent on official business with the Council plus actual and necessary traveling expenses. The Council will be required to meet not less frequently than twice a year and whenever at least four of the members request a meeting. The Advisory Council will advise the Surgeon General with reference to *questions of general policy and administration* in carrying out the provisions of this particular section of the bill, including (1) professional standards of quality to apply to personal health service benefits; (2) designation of specialists and consultants; (3) methods and arrangements to stimulate and encourage the attainment of high standards through the services of general or family practitioners, specialists and consultants, laboratories and other auxiliary services, and through the coordination of the services of physicians and dentists with those of educational and research institutions, hospitals and public health centers, and through other means; (4) standards to apply to participating hospitals, to the relations or coordination among hospitals and to the establishment and maintenance of the list of participating hospitals; (5) adequate and suitable methods and arrangements of paying for personal health service benefits; (6) studies and surveys of personal health services and of the quality and adequacy of such services; (7) *policies and procedures for determinations of disability*; and (8) grants-in-aid for professional education and research projects. Under the first bill the Advisory Council was also directed to advise the Surgeon General with respect to the establishment of special advisory, technical, local or regional boards, committees or commissions. Under the pending bill the Advisory Council is authorized to establish such groups, whose membership may include members of the Council or other persons or both, to advise on general or special questions, professional and technical subjects, questions concerning administration, problems affecting regions or localities, and related matters.

#### SELECTION OF PHYSICIANS; ACCEPTANCE OF PATIENTS; PANELS

The Surgeon General will be required to publish and otherwise make known in each local area to individuals entitled to benefits the names of medical and dental practitioners and groups of practitioners who agree to furnish services as benefits and to make such lists of names readily available to individuals entitled to benefits. A new provision in the pending bill provides that such lists must include general or family practitioners and qualified specialists and consultants. With respect to qualified specialists and consultants the lists must indicate the class or classes of specialist or consultant services for which each has been qualified. Any physician, dentist or nurse legally qualified by a state to furnish any services included as personal health service benefits will be legally qualified to furnish such benefits, including any group of physicians, dentists or nurses or combinations thereof whose members are similarly qualified. A limitation contained in the first bill conditioning the participation by a physician on rules and regulations prescribed by the Surgeon General has been eliminated.

Likewise a beneficiary may select any practitioner appearing on a panel to treat him subject to the consent of the practitioner or the group of practitioners, as the case may be. This freedom

of choice of practitioners is conditioned, however, on the right of the Surgeon General to prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish services, and such limits may be nationally uniform or may be adapted to take account of "relevant factors". A restriction in the old bill that the freedom of choice of physician must be exercised in accordance with such rules and regulations as the Surgeon General may prescribe has been eliminated. A new provision, however, has been added to the effect that every beneficiary and every group of beneficiaries will be permitted to make selection of a practitioner through a representative of his own choosing.

As in the bill introduced in the Seventy-Eighth Congress, the services of specialists, or consultants as added by the pending bill, will ordinarily be available on the advice of the general practitioner. This is modified in the new bill so that such services may be made available on the advice of a specialist or consultant attending the individual or "when requested by an individual entitled to specialist and consultant services as benefits and approved by a medical administrative officer appointed by the Surgeon General".

The Surgeon General will designate what shall constitute specialist or consultant services. He will likewise determine who are qualified to render such services, in accordance with general standards prescribed by him after consultation with the Advisory Council. In establishing standards and in designating specialists and consultants, the Surgeon General will be required to "utilize standards and certifications developed by competent professional agencies" and must "take into account the personnel resources and needs of regions and local areas".

#### PAYMENTS FOR THE SERVICES OF PRACTITIONERS

Payments to general medical and family practitioners or to general dental practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule, (2) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioners list, (3) on a salary basis, full time or part time or (4) on a combination or modification of these bases, as the Surgeon General may approve. The method of payment will apparently be determined in each local area as the majority of the general medical and family practitioners or of the general dental practitioners, respectively, may elect. A new proviso authorizes the Surgeon General to make payments by another method from the one selected in a local area to those general medical and family practitioners or general dental practitioners who do not elect the method designated by the majority. Any of the methods of making payments indicated in the foregoing may be used, as the Surgeon General may approve, in making payment to groups of practitioners that contain designated specialists or consultants as well as general or family practitioners. The Surgeon General may negotiate agreements or cooperative working arrangements to utilize inclusive services of hospitals and their staffs or attending staffs and may enter into contracts for such inclusive services.

Payments to designated specialists and consultants may be made on the basis of salary (whole time or part time) "per session", fee



for service, per capita or other basis or combination, as the Surgeon General and the specialists and consultants may agree.

Rates or amounts of payment for particular services or classes of services may be nationally uniform or may be adapted to take account of relevant regional or local conditions and other factors. The bill contains a new provision that payments shall be adequate, "especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists and nurses, having regard for age, specialization and type of community". Payment will be commensurate with skill, experience and responsibility involved in furnishing service. In any local area where payment for services of a general or family practitioner is only on a per capita basis, the Surgeon General, the bill proposes, shall make per capita payments on a pro rata basis among the practitioners and groups of practitioners of the local area on the panel with respect to those individuals who after due notice have failed to select a general or family practitioner or who, having made one or more successive selections, have been refused by the practitioner or practitioners selected.

In each local area the provision of general medical or dental benefits will be a collective responsibility of all qualified general medical or family practitioners or of all qualified general dental practitioners, respectively, in the area who have undertaken to furnish such benefits.

#### HOME NURSING BENEFITS

The bill provides that home nursing benefits shall ordinarily be available only on advice of a legally qualified attending physician but may be made available also when requested by an individual entitled to the benefits and when approved by a medical officer designated by the Surgeon General. The method to be used in paying for home nursing services is not clear.

#### LIST OF PARTICIPATING HOSPITALS

The Surgeon General is directed to publish a list of institutions which he finds to be participating hospitals in accordance with general standards prescribed by him after consultation with the Advisory Council. Any institution which is not included in the list, or any institution having been removed from the list, may petition the Surgeon General for a hearing. The bill provides that the Surgeon General shall exercise no supervision or control over a participating hospital unless it is owned or leased and operated by the United States. No requirement for participation by a hospital may prescribe its administration, personnel or operation.

#### LIMITATIONS ON GENERAL MEDICAL, GENERAL DENTAL, HOME NURSING AND LABORATORY BENEFITS

The Surgeon General, after consultation with the Advisory Council and subject to the approval of the Administrator of the Federal Security Agency, may determine that every individual entitled to general medical, general dental or home nursing benefits may be required by the physician, dentist or nurse attending him to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment if he believes that such limitation is necessary and desirable to prevent or reduce abuses of entitlement to the benefits.

The maximum amount of such fee shall be fixed by the Surgeon General after consultation with the Advisory Council and with the approval of the Administrator of the Federal Security Agency. He may also limit the application of such fees to home calls, to office visits or to both.

A new provision in the bill would authorize the Surgeon General, after consultation with the Advisory Council and with the approval of the Administrator of the Federal Security Agency, to restrict the content of the general dental, special dental or home nursing benefit. On and after Jan. 1, 1947, however, the restricted content of the general dental or special dental benefit must include at least (1) examination (including X-rays) and diagnosis, (2) prophylaxis, (3) extraction of teeth which are considered by the dentist and an attending physician to be or likely to be injurious to the general health of the individual and (4) treatment of acute diseases of the teeth, their supporting structures and adjacent parts, including fractures of the teeth or jaw. He may also fix an age above which the restrictions on content shall apply.

As to the home nursing benefits, restriction of content may limit the service to part-time care on an hourly or visit basis or may limit the types of cases for which such benefits shall be available, or the maximum amount of service per case, or otherwise.

The maximum number of days in any benefit year for which an individual may be entitled to hospitalization will be sixty (thirty in the bill introduced in the Seventy-Eighth Congress). This maximum may be increased to not more than one hundred and twenty days in a calendar year if funds are adequate.

No application for hospitalization benefits will be valid with respect to any day of hospitalization if filed more than ninety days after such day, or with respect to any day of hospitalization more than thirty days following the diagnosis of tuberculosis or psychosis, or with respect to any day in a hospital or other institution for mental or nervous disease or tuberculosis.

Likewise the Surgeon General, after consultation with the Advisory Council and with the approval of the Federal Security Administrator, may limit for any calendar year or part thereof the cost of laboratory benefits. Such limitation may relate to a class of services, supplies or commodities, to maximum payments per beneficiary in a benefit year, or to a specified fraction of the cost or to combinations thereof.

#### PROPOSED METHOD OF ADMINISTRATION

The bill provides that the Surgeon General shall perform the duties imposed on him under the supervision and direction of the Federal Security Administrator and after consultation with the Advisory Council *as to questions of general policy and administration*. He will be authorized to take all necessary steps to arrange for the availability of the benefits provided. He will be authorized, after consultation with the Advisory Council *as to questions of general policy and administration* and with the approval of the Administrator to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any state or political subdivision, and with other appropriate public agencies. He may, too, make such agreements or arrangements with private persons or groups of persons to utilize their services and facilities



and to pay fair reasonable and equitable compensation thereof. He may negotiate and periodically renegotiate agreements or cooperative working arrangements for the purchase or availability of supplies and commodities necessary for the benefits provided in the bill and to enter into contracts for such services, facilities, supplies and commodities.

Except with respect to state or local areas for which other arrangements have been made, the Surgeon General will be directed to appoint local area committees to aid in the administration of the part of the bill relating to compulsory health insurance. These committees will include representatives of persons entitled to receive services and benefits, the practitioners, the groups of practitioners, institutions and agencies furnishing services as benefits, and other persons informed on the need for, or provision of, personal health services. Such committees, the bill provides, must be consulted at frequent intervals and must be kept informed by the local area officers of the Public Health Service with respect to arrangements for the availability of benefits and policies to be followed.

The Surgeon General will be directed to give priority and preference to utilizing the facilities of state and local departments or agencies on the basis of mutual agreements with such departments or agencies. He may delegate to any officer or employee of the United States Public Health Service or of any Federal, state or local cooperating department or agency such of his powers and duties, except the prescribing of rules and regulations, as he may consider necessary and proper. He may, after consultation with the Social Security Board, after consultation with the Advisory Council *as to questions of general policy and administration*, and with the approval of the Federal Security Administrator, prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of the bill, as may be necessary.

The Surgeon General will be required to make a full report to Congress, at the beginning of each regular session, of the administration of the functions devolved on him by the bill, and such reports must include "a record of consultation with the Advisory Council, recommendations of the Advisory Council, and comments thereon".

#### RELATION TO WORKMEN'S COMPENSATION BENEFITS

No individual will be entitled to any personal health service benefits with respect to any injury, disease or disability on account of which any medical, dental, home nursing, laboratory or hospitalization service is being received, or on application would be received, under a workmen's compensation plan for the United States or of any state.

#### BENEFITS FOR NONINSURED PERSONS

Benefits may be extended to noninsured persons on behalf of whom equitable payments are made or assured by public agencies of the United States, the several states, or any of them or of their political subdivisions. The bill specifically extends this provision to groups of persons for whom the Congress makes provisions under the Social Security Act and other acts of Congress.

The Surgeon General and the Social Security Board will be jointly given the duty of studying and making recommendations as to the most effective method of providing dental, nursing

and other benefits not already provided for and of reporting their recommendations as to legislation from time to time but not later than two years after the enactment of this bill. The studies and recommendations will relate to expected costs for the additional benefits and a desirable division of the costs between (1) financial resources of the social security system or other public fund and (2) payments to be required of beneficiaries receiving such benefits. Specifically the Surgeon General and the Social Security Board are mandated to study and make recommendations as to needed services and facilities for the care of the "chronic sick" afflicted with physical ailments and for the care of individuals affected with mental or nervous diseases, recommendations as to legislation to be submitted from time to time but not later than three years after the enactment of this bill.

#### GRANTS-IN-AID FOR MEDICAL EDUCATION, RESEARCH AND PREVENTION OF DISEASE AND DISABILITY

With the exceptions noted, the provisions in the pending bill authorizing grants for medical education, research and prevention of disease and disability are identical with those that were contained in the original Wagner-Murray-Dingell bill. Under these provisions the Surgeon General will be authorized to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants will be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the Council and *after consultation with other Federal departments and agencies concerned with research or professional education* that the project shows a promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, dental, nursing hospital, laboratory disability, rehabilitation and related benefits, or to human knowledge with respect to the cause, prevention, mitigation or method of diagnosis of treatment of disease and disability.

Another new provision would make it mandatory that the Surgeon General and the Advisory Council give preference and priority, during the five-year period beginning Jan. 1, 1946, to grants-in-aid with respect to projects to aid servicemen seeking postgraduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services and related services.

To finance this part of the program a certain percentage of amounts expended for benefits from the social security trust fund will be set aside. The amount to be set aside, the bill provides, will equal 1 per cent of the total amount expended for benefits from the trust fund, exclusive of unemployment insurance benefits, or 2 per cent of the amount expended for personal health service benefits after the latter benefits have been payable for not less than twelve months, whichever is the lesser, in the last preceding fiscal year.

#### EXISTING PREPAYMENT PLANS

Senator Wagner believes that the enactment of S. 1050 will not necessarily result in the displacement of the existing prepayment medical service and hospitalization plans. In the state-



ment that he made to the Senate when the bill was introduced, he said:

"There has been much misunderstanding about the part that voluntary hospitals, group service organizations, existing voluntary insurance or prepayment plans and similar agencies may play in the social insurance system. Let me emphasize that our bill makes a place for them, so that they can continue their good work. All qualified hospitals, all qualified medical groups or organizations, will be able to participate in the program as organizations that will furnish services to the insured persons who choose them, they will receive fair payments for the services they furnish as insurance benefits and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade unions, consumer groups, employers, nonprofit community groups, churches, fraternal associations, groups of doctors or individual doctors, medical societies or many other kinds of sponsors or combinations of sponsors. The bill not only provides for utilizing existing service organizations but it also encourages the creation of new ones.

"The Blue Cross hospital insurance plans will be able to continue to act as representatives of the participating hospitals and the community groups that own or manage the hospitals, and they will have large opportunities to be important public organizations that facilitate the administration of vital parts of the insurance system. The same will be true of many other community and public organizations.

"Medical service groups (private clinics, salaried staffs of hospitals, group-service plans such as the Kaiser or the Ross-Loos plan) furnishing service under the social insurance system would be as free as they are today to select their own staffs and their own method of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area."

The bill itself, however, does not specifically mention existing prepayment medical service and hospitalization plans. It does direct the Surgeon General, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to make agreements or arrangements with private agencies or institutions, or with private persons or groups of persons, to utilize their services and facilities. To what extent the importance and effectiveness of existing plans could be preserved under such agreements or arrangements is a matter about which many will entertain serious doubts.

Dr. William E. Lower has been awarded the Distinguished Service Award of the Academy of Medicine of Cleveland for 1945. Long active in behalf of the scientific progress of medicine, Dr. Lower is a past-president of the Academy and has served on many important committees, as a section officer and a member of the Board of Directors. In May, 1938, he made the initial contribution of \$7,500 to the Lower Fund to provide for an annual lecture or annual series of lectures by men of outstanding ability and accomplishment. Each year he has added substantially to the Fund which has now reached \$10,000.

### Watch for This Resumé

**A** RESUME of legis'ation affecting medicine and public health considered by the 96th Ohio General Assembly, which is scheduled to adjourn about the middle of July, will be published in the August issue of *The Ohio State Medical Journal*. Enacted bills of particular interest to physicians will not become effective until after August 1.

### Ten-Point Tuberculosis Program Is Announced by Division Chief

Dr. Mark W. Garry, chief, Division of Tuberculosis, Ohio Department of Health, has announced the following ten-point program of activities for his division for 1945-1946:

Development and maintenance of a central tuberculosis register.

Development of case reporting through local health departments.

Stimulation of more complete reporting of tuberculosis by private physicians.

Stimulation of epidemiological investigations, with concentration of activity upon contacts of known cases.

Provision of advisory services to local health organizations and assistance in the development of local tuberculosis control programs.

Provision for tuberculosis nursing consultation.

Cooperation with other state agencies directly responsible for rehabilitation of persons with arrested tuberculosis.

Establishment of effective working arrangements with other divisions of the State Health Department and other state departments.

Participation in educational programs for tuberculosis control for the public and professional groups.

Survey of selected population groups by direct operation of a photofluorographic unit.

Richard W. Morse, Akron, has been appointed a member of the Ohio Industrial Commission, for a term to begin July 1, 1945, and ending June 30, 1951. He succeeds James A. White, Columbus, as representative of employers on the Commission. A member of the Workmen's Compensation Committee of the Ohio Manufacturers' Association, Morse has represented the Firestone Tire & Rubber Company in safety and compensation matters for a number of years.



# Army Medical Corps Praised for Outstanding Achievements; Future Problems Are Outlined by Patterson and Kirk

**A**CHIEVEMENTS of the Medical Corps of the Army were reviewed and some of the future problems confronting the Medical Department were outlined by Under Secretary of War Robert P. Patterson and Surgeon General of the Army Norman T. Kirk in a recent press and radio conference.

In introducing Major General Kirk, Secretary Patterson paid a high tribute to the Army Medical Corps, saying in part:

"The war in which we are engaged has produced many seemingly unsurmountable problems, problems without precedent in the development of new weapons, new methods of training, and new tactics. But none of these problems has been more difficult than the problems faced by our Medical Department in caring for the largest American Army in history, fighting in virtually all parts of the world. And yet, despite these problems, no Army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war.

"The Medical Department, its doctors, its nurses, its corpsmen, has saved the lives of 97 out of every 100 men wounded in battle who reached a hospital, compared with 92 in the World War. Seventy out of every 100 wounded overseas were returned to duty, and 27 were evacuated to this country.

## DISEASE DEATH RATES COMPARED

"During the past three years, the Medical Department has maintained a record of less than one death from disease per 1,000 men per year. During World War I, 19 out of every 1,000 men died each year from disease. During the Spanish-American War we lost 26 out of every 1,000 per year, and in the Civil War, 65 out of every 1,000 men died each year from disease.

"In all, during this war, 12,000 men died from disease from December 7, 1941, to May 1, 1945. In World War I, 62,670 men died from disease; in the Spanish-American War, 3,500 died from disease, and in the Civil War, 336,216 men of the Union and Confederate armies died from disease.

"Malaria has been reduced from hundreds of cases per 1,000 men per year to less than 50. The dysenteries, which once put entire regiments and armies out of action, have occurred among less than 90 out of every 1,000 men per year and have been readily controlled. During World War I, 38 per cent of the men who contracted meningitis died, compared with 4 per cent in the present war, and 24 per cent of those who caught pneumonia died in 1918 compared with only sevenths of one per cent in this war.

"The Medical Department today is well prepared for the intensification of its work brought about by the cessation of hostilities in Europe. Thousands of wounded veterans in the European and Mediterranean theaters are being transported to the United States as fast as ships and planes are available. Physical examinations are being given to each of the 3,500,000 soldiers in those theaters before they are redeployed. And Medical Department personnel will be sent to the Pacific in ever-increasing numbers as our forces are marshalled for the final blows against Japan.

"The peak of the Medical Department's activities will not be reached until the Fall of 1945. At present, wounded and sick are being returned to this country from all theaters at the rate of 44,000 a month. This evacuation will continue until all of the patients in the European and Mediterranean theaters are removed, which will require 90 days.

## HOW WOUNDED ARE TRANSPORTED

"In anticipation of the movement of patients from Europe to this country, the Army has provided seven additional hospital ships, three of which are now in service, with four more to be commissioned shortly. This will bring the total number of hospital ships to 29, with an aggregate patient capacity of 20,000. Of the 25 Army hospital ships now in operation, 18 are in the Atlantic, five are in the Pacific, and two more are en route to the Pacific.

"In addition to these hospital ships, special hospital equipment has been placed aboard 24 troop transports, giving the Army an additional patient-carrying capacity of 40,000.

"Eight thousand patients a month are being brought back to the United States by plane, with three-fourths of this air traffic over the Atlantic.

"The arrival of these thousands of wounded and sick in this country during the next three months will place a heavy load on our General and Convalescent hospitals. The population of all Army hospitals in the United States at present is 290,000. By September, this is expected to reach 315,000, taking into consideration the discharge rate.

"It can readily be seen that the Medical Department will be operating at capacity for many months to come and there will be a critical need for its professional and civilian personnel during this period."

## GENERAL KIRK'S REPORT

General Kirk's statement on health conditions in the Army and concerning its achievements follows:

"The Army Medical Department is well prepared to maintain its record of saving lives and



guarding against disease in the second phase of World War II which will be centered in the Pacific. As combat activities increase in that area troops moved from European theaters will find a different type of warfare, different diseases and different methods of combating disease.

"The Medical Department has been preparing for years for its fight on disease in the Pacific. In addition to its intensive research into diseases common to that area it has gained much value in practical application of its methods from the campaigns already fought.

"In the Pacific areas our fighting men are exposed to many types of disease that are rare in the United States and Europe. However, this should not be considered cause for alarm. With proper preventive measures and medical service the disease rate in the Pacific will be kept to a minimum.

"Every fighting unit in the Pacific area has had the same type of medical organization accompanying it as those in other theaters. The chain of evacuation of the wounded is well organized and is very effective. Because of geographical and climatic differences certain changes were desirable, but the same high type facilities are available.

#### MAIN PROBLEMS OF THE PACIFIC

"The main diseases to be encountered in the Pacific are malaria, the dysenteries, scrub typhus, skin infections, schistosomiasis, filariasis and dengue fever. Excellent progress has already been made in keeping the incidence of all of these diseases to a very low degree.

"Malaria, for example, has been reduced to one-fourth its incidence in the early part of the war so that the overall death rate from malaria in the Army is .01 per cent.

"The use of D.D.T. and atabrine is primarily responsible for lowering the incidence rate of the most disabling tropical diseases. The remarkable record in lowering the malaria rate is due also to strict discipline and control measures. Malaria is spread by the anopheles mosquito. D.D.T., a recently developed insecticide, is used to kill this mosquito and the larva. Areas are sprayed with D.D.T. by plane and a five per cent solution of D.D.T. sprayed on barracks walls in kitchens and huts kills all mosquitoes and flies alighting thereon for months after spraying.

"The dysenteries, so common in the Pacific areas, which are spread by flies are also rendered less prevalent by the use of D.D.T.

"Atabrine has been found more effective as a therapeutic agent in the control of malaria than quinine.

"Filariasis, which is also spread by the mosquito, is reduced by the use of D.D.T. and mosquito control methods.

"Schistosomiasis is caused by a small fluke found in pools and running streams which in a

matter of seconds burrows through the skin and infects the individual. All water found to contain these flukes is posted and personnel is warned not to bathe, wade or wash in it.

"Areas found to contain scrub typhus are immediately burned over, clothing is impregnated, and efforts are being made to develop a vaccine to counteract it.

"Dengue fever, also spread by the mosquito, is controlled by the use of D.D.T. and mosquito abatement.

#### D.D.T. MIRACLE DEVELOPMENT

"It can readily be noted that D.D.T. is one of the miracle developments of this war.

"Last year a tropical disease center was opened by the Army Medical Department at Moore General Hospital, Swannanoa, North Carolina. It was designated as a center for the study and treatment of tropical diseases. This center has assisted greatly in the investigation and treatment of these diseases and has reduced the loss of manpower as a result of illness, thereby making an important contribution to the continuing improvement of American medicine.

"In addition to protecting the soldier from diseases of the tropics the Army Medical Department is affording all possible protection against disease and harmful pests which might be brought into the United States by military traffic. This is done through a quarantine branch which works in conjunction with the U. S. Public Health Service and the Navy.

"The Army Medical Department has complete medical and sanitary surveys of all the territory in the Pacific which is potential battle ground. The health hazards to soldiers are known to the Medical Corps officers who accompany all invasion troops and that knowledge is distributed to all the men. The Army Medical Department has been doing a fine job in the Pacific and will continue to do that job as activities in that theater increase.

"While all of this work and planning was going on for the increased activity in the Pacific the Army Medical Department during 1944 took care of 4,435,000 patients in hospitals—2,315,000 in the United States and 2,120,000 in hospitals overseas. In addition it provided care for an additional 43,210,000 non-hospitalized patients—those with minor infections and injuries who were only temporarily incapacitated.

"It performed the essential functions of caring for men wounded in battle, the injured and the sick to maintain fighting strength with 45,000 medical officers, 15,000 dentists, 52,000 nurses, 2,000 veterinarians, 18,700 medical administrative corps men, 2,500 sanitary corps specialists, 1,000 physical therapists, 1,500 dietitians, 61 pharmacy corps officers, 535,000 enlisted medical aid men and approximately 80,000 civilian employees."

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### IF YOU WANT TO BE LISTED AS A SUPPORTER, SPEAK UP!

In the June issue of *The Journal*, there appeared a detailed article regarding Ohio Medical Indemnity, Inc., an insurance company being organized by the medical profession of Ohio to provide indemnity coverage for the costs of medical and surgical care. Additional reference to the company will be found elsewhere in this issue.

The officials of the Ohio State Medical Association would be interested in receiving from members an expression of opinion on this project being backed by the State Association. Did you read the article in the June issue? If so, what are your views on it? Will you support it?

Quite a large number of members have expressed themselves as believing the undertaking has great merit and have offered to assist. That Ohio Medical Indemnity, Inc. will succeed is a certainty in the minds of its sponsors as they believe the doctors of Ohio—most of them anyway—are convinced that this represents a concrete effort by the medical profession itself to meet a real problem; that it is a constructive endeavor to do a job through voluntary methods.

In our opinion an editorial appearing in the May 19, 1945, issue of *The Saturday Evening Post*, entitled "The States Are Feeling the Heat," sets forth in a few words the basic reasons for the organization and successful operation of Ohio Medical Indemnity, Inc. Said the *Post*:

"Whatever may prove to be the ultimate fate of nationally sponsored state medicine, the agitation in its favor and the bills which have been drafted to bring it about have had the effect of building a fire under the medical profession, as well as states, municipalities and industries. The public demand for prepaid medicine is being met in at least a dozen states by various plans to provide insurance against medical expenses. The common difference between these state plans and the Federal plan, as outlined in the Wagner-Dingell-Murray bill, is that the state plans are on a voluntary basis. It seems to us an important distinction.

"In Maryland the care of the poor, who are unable to pay anything for medical service, is treated as a separate problem from that of the middle class, which can afford to pay something but may prefer to participate in an insurance scheme. The very poor, the chronically ill, the insane and certain other classifications are taken care of by the state at the expense of the taxpayers. Funds are provided for an expansion of facilities for these purposes. For employed people a system of medical-care insurance is set up in cooperation with the Associated Hospitals

(Blue Cross) under which citizens may purchase insurance covering specified medical services.

"The plan is administered by a board of physicians and surgeons who promise that 'more liberal enrollment policies and wider coverage in every field of medicine will be developed just as fast as experience warrants'. Right there, it seems to us, lies the best argument for state and local voluntary insurance plans as against the vast compulsory proposals from Washington. In an area in which the limitations and possibilities of such a plan are immediately seen it is possible to relate demand to supply in a way which would be far more difficult in a national scheme planned in advance down to the last pill. Anyway, the Federal planners will do well to watch how these state insurance schemes operate."

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### SHARP PRACTICES OF A FEW HARMFUL TO ENTIRE PROFESSION

A few Ohio physicians are consistently violating the rules and regulations governing the Emergency Maternity and Infant Care Program being administered by the Ohio Department of Health for the benefit of eligible wives and children of enlisted servicemen.

These violations in some instances are because the physician is not familiar with the regulations; in others because he apparently flatly refuses to abide by the regulations. In either event there seems to be no good excuse and the quicker this habit is curbed, the better.

The outstanding violation, although only a comparatively few doctors are involved, is the practice of the physician of charging the serviceman's wife a fee in addition to the maximum amount allowed in the fee schedule of the E.M.I.C. program.

The regulations, laid down by the U. S. Children's Bureau, and which must be followed by the Ohio Department of Health, provides that the physician's services can not be authorized and the department can not assume financial obligation unless the physician agrees to accept the fees stipulated by the program as payment in full.

If a physician does not like the E.M.I.C. program and refuses to take such cases, that's his business. However, when a doctor does take an E.M.I.C. case, he has to accept the bitter with the sweet. He is obligated to abide by the terms laid down in the regulations. One of these terms is that he must agree not to charge the patient a fee for his services but must accept the amount, or amounts, paid by the department.

A physician who fails to follow this rule does





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RESEARCH IN THE SERVICE OF MEDICINE

the patient an injustice. Technically, the department is not permitted to approve the claim for payment if an additional amount is paid by the patient out of her own resources. Such a practice creates ill will between the patient and the physician, especially when the former has the understanding that payment in full is to be made by the department. More than that, it constitutes anything but good public relations, being regarded by the public as a "sharp" practice.

Questionable actions of this kind on the part of a few doctors cast a shadow on the ethics and honesty of the entire profession and lend encouragement to moves to regiment and straight-jacket all doctors. Unfortunately, some of the agitation for government-controlled medical service stems from these comparatively few cases in which the doctor has been unfair or undiplomatic or dishonest.

The doctor who takes an E.M.I.C. case should do so with his eyes open and with the understanding that he will abide by the regulations governing the program. If he doesn't like the program or the regulations or the fees, he should tell the serviceman's wife to look elsewhere for medical attention unless she desires to engage him on a private physician-patient basis. In such event a mutual agreement regarding fees can be worked out or the services can be provided without charge, as some physicians are doing in cases of servicemen's families.

#### MEDICAL INFORMATION CENTER FOR DISCHARGED VETERANS

A medical information center which will provide free medical advice and counsel to discharged veterans confronted with health problems has been established in Columbus through the joint efforts of the Columbus Academy of Medicine, the Red Cross, the Metropolitan Health Council and the Veterans' Information Center.

In our opinion this a sound and practical approach to a problem which will become increasingly important. Similar services should be established in other communities under the guidance of local medical societies.

The Columbus medical information center is open from 8 to 10 p. m. one day each week when at least four Columbus physicians are in attendance for consultations on psychiatric, orthopedic, industrial, general medical and family medical problems.

Sponsors of the service state that there is a need for a center where returning veterans can go for confidential talks regarding their health problems and perhaps discuss reasons for their medical discharge. It has been pointed out that the work done by the staff at the center is not a thorough medical examination but merely a "curbstone" diagnosis to afford the veteran the opportunity to get a more clear picture of his

physical condition and to suggest the proper mental outlook on his particular case. The center does not provide medical treatment and does not intend to do so.

This, and similar methods, of helping the returning veteran to get readjusted—voluntary methods underwritten by civic-minded individuals and organizations in contrast to the routine official procedures—will pay real dividends both to the discharged veteran and the community.

#### PUBLIC RELATIONS START WITH THE INDIVIDUAL DOCTOR

In his annual report to the membership of the Cleveland Academy of Medicine, Dr. C. E. Kinney, chairman of the Academy's Committee on State and Municipal Legislation, made this pointed comment:

"The Academy of Medicine of Cleveland and Cuyahoga County Medical Society should either actively support:

"1. A very marked expansion of a properly directed program of public enlightenment on matters pertaining to medicine and public welfare, and

"2. Carry these ideas into the state and national associations, or

"3. Completely abolish this and similar committees in this society."

We doubt if Dr. Kinney actually means that a local legislative committee should be abolished unless the county medical society carries on a "program of public enlightenment". What he probably meant to infer is that the legislative committee can not do the right kind of a job unless its activities are accompanied by a proper public relations program. With that, we agree. Too many times the individual physician and the county society as a whole sit back with folded hands, expecting a few men on the legislative committee to pull rabbits out of the hat. It won't work.

Regardless of whether his local society carries on or doesn't carry on a program of public enlightenment, the individual physician himself can be a one-man public relations committee. The point has been well put editorially by *New York Medicine*, official publication of the Medical Society of the County of New York, as follows:

"While much can be done through medical societies to create public understanding and sympathy with the purposes of the profession as a whole, all of these efforts must fail dismally if the individual physician in his daily contacts with representatives of the public in all walks of life fails to keep in mind and to exemplify the same spirit of friendliness, reasonableness, courtesy and consideration which his profession as a collective group is seeking to exemplify.

"Public relations thus begins at home. All too often the layman tends to judge the entire profession according to the experience he has had



with a single member of it. Every member of the medical society, therefore, is a member of the public relations committee without portfolio."

There's a lot of truth to the above observations of those who have been in touch with members of legislative bodies and who have sat in conferences with representatives of various lay groups will testify.

Don't expect your legislative committee or your society's public relations committee to pick up your fumbles and run for a touchdown. Don't forget that you and all the other members of your society are on the team, even though you may not be calling the signals.

#### PRIORITY SHOULD BE GIVEN TO THE URGENT CASE

Last month a few suggestions were offered on the matter of finding a solution to the overcrowded condition of most of the general hospitals of the state.

How one Cleveland hospital is attempting to meet this problem—especially the problem of finding a bed for the emergency patient—was described in the June issue of *The Bulletin of the Cleveland Academy of Medicine*.

Through a conference attended by members of the medical staff and the superintendent, the following new admitting rules, giving priority to the urgent case, were formulated:

1. The acutely ill patient—so-called emergency case—will have preference at all times, regardless of other bed reservations.

2. The elective medical and surgical reservations will be handled as usual.

3. The last suitable bed engaged will be taken for the acutely ill patient.

4. The doctor forfeiting the bed will be placed at the head of the following day's admission lists—staff or non-staff as the case may be.

This practical procedure is something which can, and should, be tried out in every hospital. It's a policy of give and take which must be followed under existing conditions.

#### ASSIGNING MEDICAL OFFICERS TO VETERANS' HOSPITALS STOPPED

Assignment of Army Medical Officers to the Veterans Administration against their desire has been stopped by the War Department. In a release issued June 15 from the Office of the Surgeon General of the Army, Technical Information Division, the following statement appeared:

"Additional U.S. Army Medical Corps officers will not be assigned to duty with the Veterans Administration unless they had previously been serving on the staff of that organization, Major General George F. Lull, Deputy Surgeon General of the Army, announced.

"In outlining this War Department policy General Lull stated that in the event officers specifically requested service with the Veterans Administration they would be eligible for such assignments."

This action comes on the heels of vigorous protests by the Ohio State Medical Association, through the columns of *The Journal*, and the American Medical Association to the action of arbitrarily assigning medical officers to Veterans' Hospitals. Such a policy should never have been adopted by the War Department. The department is to be congratulated for having killed this procedure.

If the War Department wants to make its record 100 per cent on this particular question, it should take prompt action with respect to those medical officers who have already been assigned to the Veterans Administration against their will.

Such officers should be disposed of in one of two ways: They should be discharged for essential civilian practice if their services are no longer needed for military duties or they should be reassigned to duty with an Army unit. The former would seem to be the wise move as apparently these men were not needed for Army services or they would not have been assigned to the Veterans Administration in the first place.

Moreover, the War Department should act with all possible speed in releasing for civilian practice all medical officers no longer needed at Army establishments. One source has estimated that with the contemplated release of 1,800,000 men by the Army, approximately 9,000 medical officers could be let out of the service without crippling the Army Medical Corps.

True, the Army must retain a sufficient supply for necessary duties and the job of demobilizing medical officers can not be done over night. Nevertheless, there is substantial evidence that the Army now has a fair surplus of medical officers and that far too many medical officers are now engaged in shuffling papers, practicing little or no medicine unless they have been assigned to taking care of dependents of military personnel or civilian employes at Army establishments which hardly seems to be a job for medical officers when there is a real need for civilian physicians in most communities.

Presumably the Army knows its needs and how to run its affairs. Nevertheless, reports which trickle in from medical officers here and there indicate that the so-called surpluses are not only in material and supplies—also in medical personnel. The civilian population has in general been patient, accepting the shortage of civilian doctors without too much complaint. But, the mortality among civilian practitioners is beginning to be felt—severely in some areas. There is a problem and the Army, if it can, must

help to solve it by releasing medical officers as soon as military demands permit.

Maybe it is time for Congress to interest itself in this matter. If you agree, drop the Congressman from your district a note, suggesting a checkup. A resolution recently introduced by Senator Downey of California on this question may start the ball rolling. It reads in part as follows:

"Resolved, That the Committee on Military Affairs, or any duly authorized subcommittee thereof, is authorized and directed to make a full and complete investigation with respect to the relative needs of the armed forces and the civilian population for the services of medical personnel with a view to ascertaining (1) whether, as a result of developments in the war, or through more efficient utilization of medical personnel, such personnel can be released from the armed forces for civilian service without impairment of the war effort; (2) the speed with which demobilization of medical personnel in the armed forces can be accomplished as the needs of the armed forces diminish, and (3) whether any further action is necessary to insure an adequate supply of trained medical personnel to meet the future needs of the armed forces and the civilian population of the Nation. The committee shall report to the Senate at the earliest practicable date the results of its study and investigation, together with such recommendations as it may deem desirable."

## WAYS TO COMBAT THE CRIMINAL NARCOTIC ADDICT

Narcotic officials report that drug addicts are increasing their efforts to establish a source of supply among physicians and pharmacists as the high cost of illicit drugs bought from the underworld and the dilution of such drugs make it difficult for the criminal addict to satisfy his craving from that source.

This means that all physicians must be extremely careful to follow the law and regulations relating to prescribing and dispensing of narcotic drugs and be wary of the slick methods used by addicts in obtaining prescriptions or drugs.

Following is the gist of some good advice given to physicians of New York State by Garland H. Williams, a district narcotic supervisor, in a communication from him published in the *New York State Medical Journal*:

Do not write so-called narcotic prescriptions for narcotic drugs for general office use. Drugs for office use should be obtained on an official written order from a manufacturer or wholesaler.

Do not telephone a prescription to a druggist except in a case of extreme emergency. File a written prescription in all such cases at the earliest possible time.

Beware of the following methods used by the common addict and follow the suggestions noted as to how to circumvent these illicit designs:

Simulating ailments that may or may not require narcotics. (Thoroughly examine patients, take X-rays, "test meals", and perform other proper scientific tests before prescribing nar-

cotics regularly. Be extremely wary of patients who suggest that a certain narcotic is the only medication that will help them. Maximum use of non-habit-forming drugs as substitutes for narcotics.)

Stealing doctor's prescription blanks, writing their own prescriptions, and forging a doctor's signature; stealing medical bags. (Do not keep your prescription pad on your desk or in sight of an addict. Do not leave your medical bag containing narcotics on the seat of your car, or in sight of an addict in your office.)

Presentation of letters from other physicians stating that the patient is suffering from certain ailments; stating the patient is traveling home or to a hospital and requires a certain amount of drugs; showing an application from the U. S. Public Health Service Hospital, Lexington, Ky., and requesting narcotics until such time as he has to report to that institution. (Many of these letters are forgeries. It is incumbent upon the physician to determine for himself whether or not the person has a genuine medical need for narcotics.)

In all cases of suspected irregularities, telephone or write the facts to the nearest office of the United States Bureau of Narcotics.

If this advice is followed, the physician can protect himself and assist in breaking up the illicit narcotic traffic.

## WHAT THE SERVICEMEN ARE THINKING

W. M. Kiplinger, who owns and distributes weekly to thousands of business and professional men a Washington Letter, analyzing developments and trends at Washington, has just issued a bulletin entitled, "What the Servicemen Are Thinking".

It gives the substance of some of the 400 letters received by him from servicemen in response to an invitation that they express their views on things back home, etc. The replies were for the most part written in late March or early April before the German war ended. Most of the men writing are enlisted men; a few officers.

As Kiplinger puts it: "What makes their views important is that they will return to the home front, bringing their thinking with them".

Here are some of the answers in summary form. They should be of interest to doctors as doctors are going to have to see these men as patients, friends and acquaintances sooner or later, and should know something about what these veterans have been thinking about during their hitch in the service:

They want to get the war over with, and get back home.

They hope that things at home will not be changed too much.

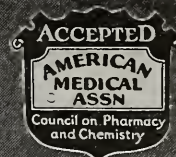
Most of all they want jobs, and some are afraid they won't get them.

They think lots of people at home have been making "big dough" out of the war, in contrast with service pay, and this irks them.

They curse out strikes and strikers. They say



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The active ingredient of Koromex Jelly is phenylmercuric acetate, whose remarkable contraceptive efficiency was affirmed in the illuminating report by Eastman and Scott (Human Fertility 9:33 June 1944). Their clinical and experimental data confirmed the earlier findings of Baker, Ranson and Tynen (Lancet 2:882 October 15, 1938). In addition to its excellent spermicidal efficacy, Koromex Jelly possesses to a high degree those other qualities which are physiologically and aesthetically so important to patients... For these reasons you can prescribe Koromex Jelly with *confidence*.



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they are not anti-labor or anti-union, but they don't like strikes at home when they are fighting abroad. The gripes on this particular subject are the most numerous, the most profoundly profane.

They suspect that many people don't know there's a war on. Particularly they resent civilian grumbling over the midnight curfew, and rationing, and other inconveniences which seem to them petty.

They believe in a hard peace for Germany and Japan. They growl over news reports of soft treatment for German prisoners in this country.

They wonder whether the officials at home are doing their utmost to prevent another world war.

They don't like the ads which puff some products as doing their bit for war. They say "nuts".

They don't like the movies which pour excessive glamour out upon the fighting men. They say "bilge".

They don't like to be regarded as "different" from home folks, or as a class apart. They say: "Hell, we aren't neurotic". They don't even like to be typed as "GI Joe".

Many are fed up with rules and regulations. They accept Army and Navy regulations, and gripe about them, but they also extend the gripe to governmental rules and regulations, which they fear they will have to face in civilian life. "I don't want the government regulating everything after I get back."

Gripes about Army wastefulness creep into a few letters. "We've got too many idle men behind the lines thinking up ways to look busy, and I am one of them, but it isn't my fault and I think it is a damn shame."

There's an acute interest in "small business opportunities".

A few seem to think that after this war the world owes them a living, but not many think this. They merely "want a fair chance".

Many intend to return to school or college, and the studies most often mentioned are various branches of engineering.

Concluding his analysis, Kiplinger says:

"Any reader of more than 400 letters from servicemen is bound to get certain impressions of what the men want and don't want when they come home, even though they do not always come right out and say it. They want affection, and plenty of it. They want warmth of human understanding. They don't want coddling, and they don't want hero stuff. Above all else they want jobs. That's something to think about. They want jobs."

Columbus—Dr. Frank F. Tallman, State Commissioner of Mental Diseases, addressed the local Rotary Club on: "Mental Illness—What Is It?"

## Do You Know - - -

Dr. Walter H. Judd, Congressman from Minnesota and a former medical missionary in China, spoke on "Chinese-American Relations", at a recent meeting of the Dayton Executives Club. Members of the Montgomery County Medical Society were guests at the meeting. He was introduced by Dr. A. B. Brower, immediate past-president of the Club.

\* \* \*

The honorary degree of doctor of laws was presented to Dr. Charles E. Holzer, Gallipolis, at the recent commencement of Ohio State University. Dr. Holzer was cited as "an outstanding citizen, devoted to public service, an organizer and promoter of productive enterprises of economic and social importance".

\* \* \*

An indication of the effect of the war on the medical profession is revealed in the decrease in professional listings in the latest edition of the Cincinnati telephone directory. In four years the number of physicians and surgeons in the classified section has dropped from 1,042 to 787.

\* \* \*

"How's the Patient?", the radio health program sponsored by the Columbus Academy of Medicine, celebrated its 300th consecutive weekly broadcast over Station WBNS, June 9. The program has been under the direction of Dr. Jonathan Forman since Dr. H. M. Clodfelter, who initiated it, entered the Medical Corps of the Navy about three years ago.

\* \* \*

There is a vacancy for a male or female physician as House Officer for the International Grenfell Association Hospital, St. Anthony, Newfoundland. The hospital has 80 beds, with two auxiliary annexes of 20 beds each. This organization provides the only medical care for North Newfoundland, and the position offers unique and valuable experience. The vacancy occurs in August, or as soon after as possible, for one year. Full maintenance, including family accommodations, and travel, provided. The salary is dependent on the applicant's experience—\$2,500 for a well-qualified candidate. Apply Staff Selection Committee, International Grenfell Association, 156 Fifth Ave., New York 10, N.Y.

\* \* \*

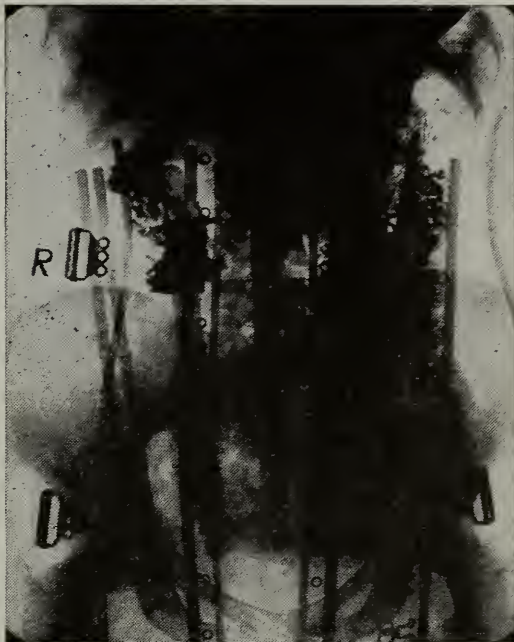
The Toledo Academy of Medicine is in the midst of a campaign to raise funds, either to modernize the present Academy building or build a new one, depending upon the amount of money subscribed.

\* \* \*

The new president of the Ohio Public Health Association is Dr. Joseph B. Stocklen, Cleveland, tuberculosis controller of Cuyahoga County for the past four years.



**WHEN** *digestive symptoms and general malaise are accompanied by marked downward displacement of the viscera, they are often relieved by ANATOMICAL SUPPORT.*



*X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.*

## Visceroptosis Support - **CAMP**

The roentgenologist may or may not find disturbed conditions in the duodenum... the displaced viscera being the only finding. For these patients, many physicians prescribe adequate rest, proper food at regular intervals, graduated exercises (especially for the patient with "visceroptotic habitus"), and a scientifically designed anatomical support. Numer-

ous reports show that this treatment results in the gradual disappearance of the digestive symptoms with improvement in general health and weight gains for the thin patient. In time the support may be discarded.

Camp Supports are also of assistance for postural defects that so frequently accompany the visceroptotic condition.



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# Private Practice Is Desired by Most Medical Officers; Many Favor Group Type of Practice, Survey Shows

SOME exceedingly interesting answers to questions touching on the economics of the practice of medicine have been received by the Committee on Postwar Medical Service through questionnaires distributed to doctors now in the services.

Following are some high spots of an analysis made of 21,029 questionnaires by Lt. Col. H. C. Lueth, a member of the Committee on Postwar Medical Service, and reported in the June 16 issue of *The Journal of the A.M.A.*

## TYPE OF MEDICAL PRACTICE DESIRED

There were 4,326 medical officers who indicated a desire to engage in general medical practice after release from service. This constituted only about three-fourths of those who entered the armed forces from general practice. Nearly two-thirds of all medical officers, 12,627, indicated that they were interested in special medical practice in the future. They were about equally divided between those who expressed a desire to engage solely in specialty practice, 6,456, and those who expressed a desire to engage in specialty practice combined with part-time teaching, 6,171.

## SIZE OF COMMUNITIES FAVORED

Medical officers who were interested solely in future specialty practice seemed to favor communities of 25,000 to 250,000 population. There were only 27 who wanted to go to communities of less than 2,500, 906 who wanted to go to communities of 2,500 to 25,000, 2,539 who wanted to go to communities of 25,000 to 250,000, and 949 who wanted to go to communities of more than 250,000 population. Nearly one-third of the group of medical officers gave no indication of the preferred size of community.

There were 2,821 medical officers who expressed a desire to engage in medical practice on a full-time basis. Included in this group were 278 men who desire to become full-time teachers.

## ACCEPTABLE MONTHLY SALARIES

One of the questions asked was "What is the minimum monthly salary you would accept on a salary basis?" A wide range of answers was given. The median monthly salary mentioned was \$583. There were 1,485 medical officers who would accept a monthly salary of \$400 to \$499, 2,610 medical officers who would accept a monthly salary of \$500 to \$599 and 1,090 medical officers who would accept a monthly salary of \$600 to \$699. There was fairly even distribution among the various graduation groups.

Eleven per cent, or 2,364 medical officers, ex-

pressed willingness to go to a different community than that from which they came if a subsidy was provided for several months. About 13 per cent of medical officers (2,817) stated that they would be willing to go to an area needing physicians if there was an office established. More than 15 per cent (3,284 medical officers) were willing to move to an area in need of physicians if diagnostic facilities were available. Nearly 29 per cent (6,091) would go to a community in need of a doctor if there were hospital facilities. The proportions in each graduation group who would go to a community needing physicians with office established, subsidy provided, diagnostic facilities or hospital facilities were about equal.

A few men wanted to go to communities of less than 2,500 population. There were 41 who would go if a subsidy was provided, 43 if there were diagnostic facilities, 56 if an office was established and 74 if there were hospital facilities available. About one-fifth of all men who were willing to relocate wished to go to cities of 2,500 to 25,000 population. Six hundred and forty-three medical officers would go to such cities if there was an office established, 531 medical officers if there was a subsidy provided, 710 if there were diagnostic facilities and 1,327 if there were hospital facilities.

Many men gave no indication of the size community they would go to but said they would go if an office was provided (631), a subsidy was provided (481), diagnostic facilities were provided (641) and hospital facilities were provided (1,166).

## FULL-TIME MEDICAL PRACTICE

About 85 per cent of medical officers indicated that they did not desire to remain in government service. Medical officers of the regular medical corps or governmental agencies were considered separately and constituted a group of 532 officers. There were 237 Regular Army officers, 181 Regular Navy officers, 15 United States Public Health Service officers, 10 Regular Veterans Administration officers and 4 regular officers from other governmental agencies who indicated their desire to remain in government service, or a total of 2,501. In addition, 49 regular officers stated that they did not want to remain in government service.

Of Reserve officers 672 men were willing to accept Army service. Naval medical service attracted 406 officers. About the same number of men (411) chose the United States Public Health Service. There were 435 medical officers who desired service with the Veterans Administration.



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18 HRS  
12 HRS  
6 HRS.

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INSULIN

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acting

GLOBIN  
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Action carries over beyond 24 hrs.

## Consider all 3 insulins for better diabetes control...

THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—"Wellcome" Globin Insulin with Zinc—is intermediate.

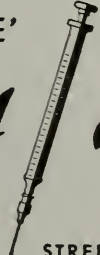
Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of "Wellcome" Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all three insulin types.

"Wellcome" Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

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About one-third of these officers graduated from medical school before 1930.

GROUP AND PRIVATE PRACTICE

The questionnaires of medical officers were divided into several categories—those wanting to reengage in individual private practice (8,041), those not desiring to reengage in private practice (1,345), those desiring private practice with a group (10,994) and those who gave no indication of their wishes (649). The distribution by graduation groups is shown in the accompanying table.

ANSWERS TO GROUP PRACTICE QUESTION

| Graduation Group No. | Dates of Graduation | Want to Re-engage in Private Practice* | Do Not Desire to Reengage in Private Practice | Desire Private Practice with a Group | No Indication of Wishes | Total  |
|----------------------|---------------------|----------------------------------------|-----------------------------------------------|--------------------------------------|-------------------------|--------|
| 1                    | 1941-1943           | 1,432                                  | 181                                           | 2,638                                | 142                     | 4,393  |
| 2                    | 1938-1940           | 1,422                                  | 198                                           | 2,461                                | 124                     | 4,205  |
| 3                    | 1935-1937           | 1,472                                  | 180                                           | 2,052                                | 58                      | 3,762  |
| 4                    | 1930-1934           | 1,999                                  | 302                                           | 2,304                                | 119                     | 4,724  |
| 5                    | 1920-1929           | 1,522                                  | 287                                           | 1,396                                | 115                     | 3,320  |
| 6                    | Before 1920         | 194                                    | 197                                           | 143                                  | 91                      | 625    |
| Total                |                     | 8,041                                  | 1,345                                         | 10,994                               | 649                     | 21,029 |

\*No indication as regards group practice. It also includes men who want to enter private practice.

CONCLUSIONS

1. More than one-fourth, or 5,785 (27.4 per cent) medical officers, were formerly in general medical practice. The smallest number of men (624) came from communities of less than 2,500 population and more than three times that number came from cities of 2,500 to 25,000, cities of 25,000 to 250,000 and cities of over 250,000.
2. About one-third (7,282 medical officers) had been in special practice in civilian life. More than three-fourths of the specialists came from large cities, and many had been certified by American boards.
3. There were 4,326 medical officers who indicated a desire to engage in general medical practice, or only about three-fourths of those who came from general practice to duty with the armed forces. In contrast, more than half again as many men who were originally in specialty types of practice before coming to duty (7,282) indicated that they would like to engage in specialty practice after the war (12,627). Medical officers interested in future specialty practice seemed to favor communities of 25,000 to 250,000 population.
4. A wide range of answers was given to the question as to the minimum acceptable monthly salary that medical officers would accept in the future. The median monthly salary was \$583, and there were slight variations for the different sized communities and larger variations between the different graduation groups.

5. Eleven per cent (2,364 medical officers) were willing to go to a new community in need of physicians if a subsidy was provided for several months. About 13 per cent of medical officers, or 2,817, stated that they would be willing to go to an area needing physicians if there was an office established. More than 15 per cent, or 3,284 medical officers, would go to such areas if there were diagnostic facilities, and nearly 29 per cent, or 6,091, if there were hospital facilities. In general a larger number of young men indicated their willingness to locate in new areas than older medical officers.

6. About 85 per cent of medical officers indicated that they did not desire to remain in government service.

7. Private practice, either individually or as part of a group, was the choice of more than four-fifths of medical officers. There were 8,041 medical officers who expressed a desire to engage in the individual private practice of medicine and 10,994 who desired to engage in private practice as a member of a group.

Dr. John H. Skavlem, Cincinnati, has been elected to the Board of Directors of the National Tuberculosis Association.

\* \* \*

Dr. Richard A. Bolt, associated with the Cleveland Child Health Association for 16 years, has moved to Berkeley, Calif., to assist in the organization of a new School of Public Health at the University of California.

\* \* \*

Dr. J. H. Norris, Fostoria, who recently celebrated his 90th birthday, has been practicing continuously in Fostoria for 66 years. He was previously located in Bowling Green for two years.

\* \* \*

Dr. Frank S. Gibson, Cleveland surgeon, received an honorary degree at the 99th annual commencement of Mt. Union College, Alliance.

\* \* \*

An address on "Functional Treatment of Fractures and Other Injuries", made by Dr. Edward Harlan Wilson, Columbus, at the 23rd Annual Session of the American Congress of Physical Medicine at Cleveland last Fall, appeared in the June, 1945, issue of *Archives of Physical Medicine*.

\* \* \*

Dr. A. R. Sweeney, a veteran of 34 years in the U. S. Public Health Service, retired recently as commandant of the Marine Hospital, Cleveland, and reported for duty in Washington, D.C. His successor is Dr. R. B. Holt, now in charge of the Marine Hospital, Sheepshead Bay, Long Island, N.Y.



# Penicillin

## DOSAGE TABLE\*

| INDICATIONS                                                                                                                                                                        | INITIAL DOSE (UNITS)                                                   | CONTINUING DOSAGE (UNITS)                                                                                          | UNITS IN 24 HR.           | REMARKS                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Serious Infections</b> (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus)<br>Adults and children | 15,000 to 20,000                                                       | (a) Intravenous drip: 2000 to 5000 every hr.                                                                       | 40,000 to 120,000 or more | (a) Dissolve $\frac{1}{2}$ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.                                     |
|                                                                                                                                                                                    |                                                                        | or<br>(b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.                                                       | 40,000 to 120,000 or more | (b) Concentration: 5000 U. per cc. normal saline.                                                                                                         |
|                                                                                                                                                                                    |                                                                        | or<br>(c) Intramuscular drip                                                                                       | 40,000 to 120,000 or more | (c) Total daily dose in 250 cc. normal saline.                                                                                                            |
| Infants                                                                                                                                                                            | 5000 to 10,000                                                         | 3000 to 10,000 intramuscularly every 3 hr.                                                                         | 20,000 to 40,000 or more  | Each dose in 1 or 2 cc. of normal saline.                                                                                                                 |
| <b>Chronically infected</b> compound injuries, osteomyelitis, etc.<br>Adults and children                                                                                          | 5000 to 10,000                                                         | 10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times. | 40,000 to 120,000 or more | Concentration for intramuscular inj.: 5000 U. per cc. normal saline.<br>For intravenous inj.: 1000 to 5000 U. per cc.<br>Supplement with local treatment. |
| <b>Gonorrhea</b>                                                                                                                                                                   | 20,000 every 3 hr. intramuscularly for 5 doses                         |                                                                                                                    | 100,000                   | Results of treatment should be controlled by culture of exudate.                                                                                          |
| <b>Empyema</b><br>Adults and children                                                                                                                                              | 30,000 to 40,000 once or twice daily into empyema cavity               |                                                                                                                    | 30,000 to 80,000          | Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.                                                            |
| <b>Meningitis</b><br>Adults and children                                                                                                                                           | 10,000 once or twice daily into subarachnoid space or intracisternally |                                                                                                                    | 10,000 to 20,000          | Concentration: 1000 U. per cc. normal saline.                                                                                                             |
| <b>Bacterial Endocarditis</b><br>Adults and children                                                                                                                               | 25,000 to 40,000                                                       | 25,000 to 40,000 every 3 hr. intramuscularly                                                                       | 200,000 to 300,000        | Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.                                                     |

\*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● Write for pocket size copies of this Dosage Table

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# Five More Names Added to Military Roster; Total Number In Services Now 3,120; Promotions Listed

FIVE new names were added to the Military Roster of the Ohio State Medical Association during the past month, making the total number of Ohio physicians in the services, after accounting for discharges, 3,120. The star (\*) prefix indicates that the man has been in service for some time but that this information was just reported to the Association. Following are the names of those commissioned, promotions, and the box score by counties:

## NAMES ADDED TO MILITARY ROSTER

| Name               | City                 | Rank                |
|--------------------|----------------------|---------------------|
| *Clark, Ivan T.    | Columbus.....        | Capt., U.S.A.       |
| *Leach, Joseph I.  | Columbus.....        | (Lt. (j.g.), U.S.N. |
| Leeds, Horace M.   | Winchester.....      | 1st Lt., U.S.A.     |
| *Ludwig, Edward W. | St. Clairsville..... | Capt., U.S.A.       |
| Schmiesing, Werner | Lima.....            | 1st Lt., U.S.A.     |
| Wood, Vernon B.    | Ironton.....         | Capt., U.S.A.       |

## WIN PROMOTIONS

| Name                   | City              | Rank               |
|------------------------|-------------------|--------------------|
| Alberts, Edward        | Cincinnati.....   | Major, U.S.A.      |
| Anzinger, Robert J.    | Springfield.....  | Capt., U.S.A.      |
| Ash, Clarence Edward   | Cincinnati.....   | Capt., U.S.A.      |
| Burt, Olan P.          | Columbus.....     | Capt., U.S.A.      |
| Campbell, Howard A.    | Dayton.....       | Capt., U.S.A.      |
| Chambers, David A.     | Cleveland.....    | Col., U.S.A.       |
| Cohen, Sander          | Cincinnati.....   | Lt. Col., U.S.A.   |
| Dreyfuss, William      | Cleveland.....    | Major, U.S.A.      |
| Engel, Walter G.       | Cincinnati.....   | Major, U.S.A.      |
| Evans, George L.       | Mansfield.....    | Major, U.S.A.      |
| Ewing, J. W.           | Akron.....        | Capt., U.S.A.      |
| Gambrel, Francis J.    | Youngstown.....   | Capt., U.S.A.      |
| Goldstein, Harry       | Cincinnati.....   | Major, U.S.A.      |
| Grogan, Francis Robert | Urbana.....       | Major, U.S.A.      |
| Hathhorn, H. E.        | Youngstown.....   | Lt. Col., U.S.A.   |
| Hepp, Herman J.        | Cincinnati.....   | Capt., U.S.A.      |
| Heppl, John A.         | Cleveland.....    | Capt., U.S.A.      |
| Hines, Robert B.       | Barnesville.....  | Capt., U.S.A.      |
| Humphries, John K.     | Belle Center..... | Major, U.S.A.      |
| Jacob, John            | Cleveland.....    | Capt., U.S.A.      |
| Kaufman, Karl Fredk.   | Bedford.....      | Capt., U.S.A.      |
| Kirk, Gilman D.        | Columbus.....     | Lt. Col., U.S.A.   |
| Kleinman, Roy B.       | Cincinnati.....   | Capt., U.S.A.      |
| Kuhn, Howard F.        | Cincinnati.....   | Lt., U.S.N.        |
| Lancione, Peter        | Bellaire.....     | Capt., U.S.A.      |
| Lapp, Henry Thomas     | Utica.....        | Lt. Col., U.S.A.   |
| Lazzari, John H.       | Cleveland.....    | Lt. Col., U.S.A.   |
| Liebow, Irving M.      | Cleveland.....    | Major, U.S.A.      |
| Longacre, Jacob J.     | Cincinnati.....   | Major, U.S.A.      |
| Lowry, Kenneth F.      | Troy.....         | Lt. Col., U.S.A.   |
| Maltby, George L.      | Cincinnati.....   | Major, U.S.A.      |
| Martin, George Isaac   | Blanchester.....  | Lt. Col., U.S.A.   |
| McCandless, Harvey G.  | Cincinnati.....   | Major, U.S.A.      |
| McClelland, E. E.      | Bellaire.....     | Major, U.S.A.      |
| Moore, William Arthur  | Cincinnati.....   | Major, U.S.A.      |
| Neidus, M. W.          | Youngstown.....   | Major, U.S.A.      |
| Picha, V. J.           | Cleveland.....    | Capt., U.S.A.      |
| Reese, Walter A.       | Middletown.....   | Lt. Col., U.S.A.   |
| Rose, James E.         | Sabina.....       | Capt., U.S.A.      |
| Schwebel, Samuel       | Youngstown.....   | Lt. Comdr., U.S.N. |
| Shoupe, Thomas Richard | Findlay.....      | Capt., U.S.A.      |
| Taliak, Martin B.      | Berea.....        | Major, U.S.A.      |
| Tamarkin, Samuel       | Youngstown.....   | Major, U.S.A.      |
| Wade, Reynolds W.      | Toledo.....       | Capt., U.S.A.      |
| Wilson, Rex H.         | Akron.....        | Major, U.S.A.      |
| Zeithaml, Carl Edward  | Cleveland.....    | Lt. Col., U.S.A.   |
| Zoss, Albert R.        | Cincinnati.....   | Capt., U.S.A.      |

## TABULATION BY COUNTIES

|                  |     |                |     |               |      |
|------------------|-----|----------------|-----|---------------|------|
| Adams .....      | 3   | Guernsey ....  | 7   | Muskingum ..  | 9    |
| Allen .....      | 40  | Hamilton ....  | 511 | Noble .....   | 1    |
| Ashland .....    | 12  | Hancock ....   | 12  | Ottawa .....  | 9    |
| Ashtabula .....  | 18  | Hardin .....   | 7   | Paulding .... | 2    |
| Athens .....     | 11  | Harrison ....  | 4   | Perry .....   | 4    |
| Auglaize .....   | 6   | Henry .....    | 3   | Pickaway .... | 5    |
| Belmont .....    | 16  | Highland ....  | 7   | Pike .....    | 2    |
| Brown .....      | 1   | Hocking ....   | 4   | Portage ..... | 4    |
| Butler .....     | 33  | Holmes .....   | 2   | Preble .....  | 7    |
| Carroll .....    | 2   | Huron .....    | 17  | Putnam .....  | 6    |
| Champaign .....  | 9   | Jackson ....   | 1   | Richland .... | 37   |
| Clark .....      | 36  | Jefferson .... | 23  | Ross .....    | 21   |
| Clermont .....   | 9   | Knox .....     | 10  | Sandusky .... | 12   |
| Clinton .....    | 8   | Lake .....     | 19  | Scioto .....  | 19   |
| Columbiana ..... | 12  | Lawrence ....  | 8   | Seneca .....  | 11   |
| Coshocton ...    | 4   | Licking .....  | 17  | Shelby .....  | 7    |
| Crawford ...     | 9   | Logan .....    | 7   | Stark .....   | 102  |
| Cuyahoga ....    | 785 | Lorain .....   | 38  | Summit .....  | 164  |
| Darke .....      | 6   | Lucas .....    | 181 | Trumbull .... | 23   |
| Defiance .....   | 4   | Madison ....   | 6   | Tuscarawas .. | 20   |
| Delaware .....   | 7   | Mahoning ....  | 139 | Union .....   | 2    |
| Erie .....       | 11  | Marion .....   | 16  | Van Wert .... | 11   |
| Fairfield .....  | 9   | Medina .....   | 13  | Vinton .....  | 2    |
| Fayette .....    | 2   | Meigs .....    | 3   | Warren .....  | 4    |
| Franklin .....   | 257 | Mercer .....   | 6   | Washington .. | 8    |
| Fulton .....     | 6   | Miami .....    | 15  | Wayne .....   | 13   |
| Gallia .....     | 5   | Monroe ....    | 0   | Williams .... | 8    |
| Geauga .....     | 4   | Montgomery..   | 163 | Wood .....    | 19   |
| Greene .....     | 8   | Morgan .....   | 3   | Wyandot ....  | 3    |
| Total .....      |     |                |     |               | 3120 |

Rollen Waterson, executive secretary of the Lake County Medical Society, Hammond, Indiana, and the Association of American Physicians and Surgeons, Gary, Ind., resigned recently to become executive secretary of the Alameda County Medical Society, Oakland, Calif.

\* \* \*

The coordinating council of the five county medical societies of greater New York is sponsoring a series of lectures on the social and economic problems of medicine for students in all medical colleges in the city. Dr. William B. Rawls, chairman of the council, opened the series with a discussion of "Organized Medicine's Effort to Meet the Changing Aspect of Medical Economics".

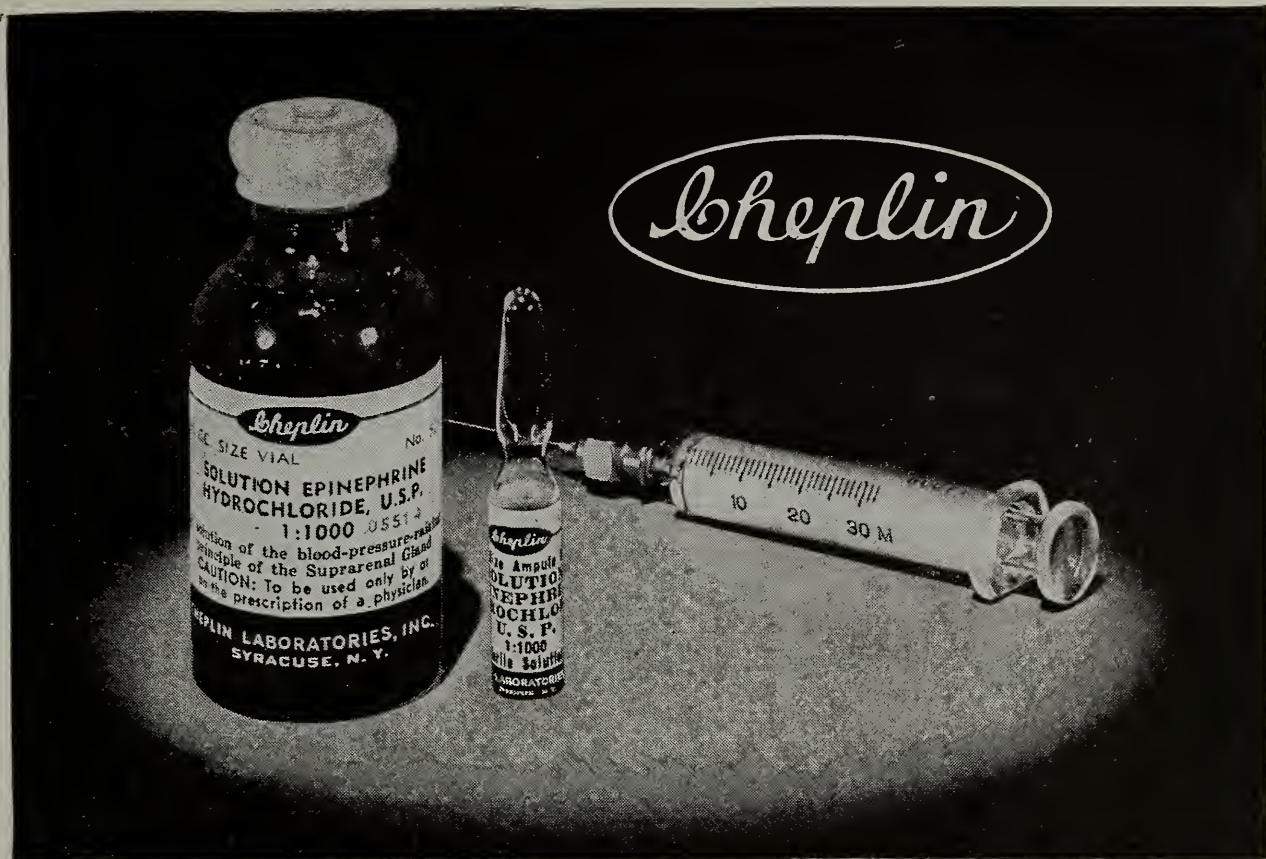
\* \* \*

Recent gifts to Ohio State University include: \$6,500 for equipment in the College of Medicine; \$1,603.82 for the Radiation Laboratory; \$174.44 for the Institute in Nutrition and Food Technology; \$100 for Sheard Research in Vision; \$500 from the Lincoln Research Laboratories, Inc., for arthritic research; \$200 from the Columbus Academy of Medicine for the College of Medicine Library.

\* \* \*

Dr. Harry L. Rockwood, superintendent of Mt. Sinai Hospital, Cleveland, for 15 years, has resigned to assume the newly created position of medical director of the Cleveland city infirmary and chronic disease hospital at Warrensville. William Seltzer, hospital administrator of New York's Bronx Hospital since 1930, is the new superintendent at Mt. Sinai.





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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### ADAMS

A meeting of the Adams County Medical Society, June 20, at the Museum of the Serpent Mound State Park, opened with a business session at 10:30 A.M., followed by an address on "Hip Fractures and Their Treatment", by Dr. John F. Lyons, Cincinnati. A picnic dinner was served at noon, for members of the society, their families and guests. Speakers at the afternoon session were: Dr. J. E. Pirrung, Cincinnati, "Surgery of the Thyroid", and Dr. Elmer A. Schlueter, Cincinnati, "Thiouracil in the Treatment of Hyperthyroidism".—Hazel L. Sproull, M.D., secretary.

### BUTLER

Dr. Douglas Goldman, medical director of the Longview State Hospital, Cincinnati, told of the treatment of 100 cases of neurosyphilis with penicillin, at a meeting of the Butler County Medical Society, May 31, at the Middletown Hospital.—News clipping.

### CLINTON

"Eclampsia", was the subject discussed by Dr. L. H. Fullerton, New Vienna, at a meeting of the Clinton County Medical Society, June 5, at the General Denver Hotel, Wilmington. The following committee was appointed on the sale of stock in Ohio Medical Indemnity, Inc.: Dr. H. R. Bath, Wilmington; Dr. Wm. L. Wead, Sabina, and Dr. Fullerton.—R. W. DeCrow, M.D., secretary.

### WARREN

At a regular meeting of the Warren County Medical Society, June 12, at Lebanon, official approval was voted of Ohio Medical Indemnity, Inc. Dr. A. E. Stout, Waynesville, president of the society, was designated, in lieu of a formal committee, to help promote the new company.—Roy C. A. Bock, M.D., secretary.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### MONTGOMERY

Dr. Alton Ochsner was the guest speaker at the annual dinner meeting of the Montgomery County Medical Society, June 6, at the Dayton Country Club. He discussed: "Neurovascular Lesions".—C. J. Derby, M.D., president.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### MARION

Dr. Richard I. Brashear, Columbus, was guest speaker at a meeting of the Marion Academy

of Medicine, June 5, at the Marion City Hospital.—News clipping.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

"Indications for Pulmonary Resection", was the subject of an address made by Dr. S. O. Freedlander, associate professor of surgery, Western Reserve University School of Medicine, Cleveland, at a meeting of the Mahoning County Medical Society, June 19, at the Youngstown Club, Youngstown.—Bulletin.

### PORTAGE

At a meeting of the Portage County Medical Society, June 7, at the Robinson Memorial Hospital, Ravenna, Dr. E. A. Simendinger, Akron, spoke on "Thyroid and Liver Relation".—Emily J. Widdecombe, M.D., secretary.

### SUMMIT

Dr. James L. Reycraft, assistant clinical professor of gynecology, Western Reserve University School of Medicine, Cleveland, spoke on "Placenta Previa—Diagnosis and Treatment", at a meeting of the Summit County Medical Society, June 5, at City Hospital, Akron.—Bulletin.

## Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

### SCIOTO

Members of the Hempstead Academy of Medicine enjoyed a talk by Dr. Ivor S. Clark, Columbus, on the subject, "Means of Preserving Vision", at a meeting of the Academy, May 14, at the Nurses' Home, Portsmouth General Hospital.—Thos. W. Frame, M.D., secretary.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### LORAIN

"Subacute Bacterial Endocarditis", was the topic discussed by Dr. Ross M. Knoble, Sandusky, at a dinner meeting of the Lorain County Medical Society, June 12, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

## WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### BUTLER

The members of the Woman's Auxiliary to the Butler County Medical Society enjoyed a picnic in the spacious gardens of Mrs. H. J.



$$1 + 1 = 1$$

To state it another way:

**ONE**

level tablespoonful  
of Pablum (or Pabena)  
when mixed with . . .

**ONE**

tablespoonful of milk,  
formula or water (hot  
or cold) makes . . .

**ONE**

rounded tablespoonful  
of cereal feeding of  
average consistency.

To make thicker feeding (as in pylorospasm, pyloric stenosis, etc.), increase the amount of Pablum or Pabena. To make thinner feeding, as in 3-months infants, increase amount of milk, formula or water.

NO COOKING . . . MIX UP ONLY AMOUNT TO  
BE FED . . . NO LEFTOVER CEREAL TO GO  
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ECONOMICAL . . . NO WASTE . . . QUICK AND  
EASY TO PREPARE . . . SINCE 1932.

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Baker's home, Hamilton, on June 10. Twenty-five members were present from Middletown, Oxford, Monroe and Hamilton. Hostesses were: Mesdames H. J. Baker, Harry Burdsall, E. T. Storer, Frank O'Neil, J. C. Stratton, W. H. Henry, David Gerber, C. A. Spitler, W. H. Williams, Arnold Leeds, Hyman Helfman and W. M. Warner.

### FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine held its annual meeting, which was followed by a musical tea, Monday, May 21, at the home of Mrs. Wynne Silbernagle, Upper Arlington. Mrs. John Briggs, president of the group for the past year, presided during the business session. Officers and committee chairmen presented the year's reports. Officers were elected and installed for the year 1945-1946. They are: Mrs. George Cooperrider, president; Mrs. Dan Sanor, vice-president; Mrs. Earl Baxter, president-elect; Mrs. Roy Krigbaum, treasurer; Mrs. Frank Riebel, recording secretary; Mrs. Ivor Clark, corresponding secretary. A musical tea concluded the meeting, with Zella Roberts and Virginia Thomas providing the entertainment. More than 85 guests were present and Mrs. John Briggs and Mrs. Cooperrider presided at the tea table.

On May 31 Mrs. George Cooperrider, new president of the Auxiliary, entertained the executive board and committee chairmen at a one o'clock luncheon in the Spanish Room at the Deshler-Wallick Hotel. Among the guests attending were: Mrs. Earl Baxter, Mrs. D. G. Sanor, Mrs. Roy Krigbaum, Mrs. Frank Riebel, Mrs. Ivor Clark, and Mrs. John Briggs. Committee chairmen were represented by the following: Mrs. Albert Frost, program; Mrs. J. C. Kirschner, social; Mrs. William Miller, luncheon; Mrs. A. J. Shoemaker, calendar; Mrs. Earl Ryan, project; Mrs. Oscar Jepson, ways and means; Mrs. L. M. Harris, hospitality; Mrs. George Peters, telephone; Mrs. Floyd Green, transportation; Mrs. James Warren, membership; Mrs. Charles Silbernagle, music; Mrs. John Wilce, *Hygeia*; Mrs. Everett Bonar, historian; Mrs. Roswell Fidler, parliamentarian; Mrs. Fred Fletcher and Mrs. I. B. Harris, auditors, and Miss Allyn Stout, publicity.

### KNOX

The Woman's Auxiliary to the Knox County Medical Society met recently with Mrs. George Imhoff, Mt. Vernon, Mrs. Cooper Russell assisting as co-hostess. The following officers were elected and installed for the 1945-46 club year: President, Mrs. John Drake; president-elect, Mrs. J. F. Lee; vice-president, Mrs. Julius Shamansky; secretary-treasurer, Mrs. Richard Gomer. A series of contests provided entertainment with prizes awarded to Mrs. Charles Bald-

win, Mrs. O. W. Rapp, and Mrs. W. W. Pennell. Refreshments were served from a beautifully appointed tea table. The next meeting will be a picnic at the home of Mrs. E. V. Ackerman, Fredericktown, Ohio.

### RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met May 7 at a one o'clock luncheon, held at the Woman's Club. Mrs. W. D. Abrams, Mrs. Charles Shafer, Mrs. H. F. Plaut and Mrs. L. D. Bonar were hostesses.

### SUMMIT

At a luncheon meeting on May 1, at the Mayflower Hotel, Akron, the Woman's Auxiliary to the Summit County Medical Society elected the following officers for the year ending May, 1946: Mrs. C. F. Wharton, president; Mrs. J. L. Brickwede, vice-president; Mrs. D. D. Traul, president-elect; Mrs. E. W. Breyfogle, delegate; Mrs. M. F. Bossart, treasurer; Mrs. A. V. Gold, recording secretary; Mrs. H. H. Klingler, corresponding secretary; Mrs. W. A. Keitzer, alternate delegate. It was voted to include a year's subscription to the *Bulletin of the Woman's Auxiliary to the American Medical Association* in the yearly dues, which were raised from \$2.00 to \$3.00. A picnic for members and their husbands is being planned for Wednesday, July 18, at Mingo Camp, Metropolitan Park.

### Plan Blood Bank

The Elyria Kiwanis Club has taken over as a special project the raising of an estimated \$8,000 to \$10,000 to carry out plans developed by a committee of the Lorain County Medical Society for the creation and maintenance of a blood bank for use of the citizens of the county. It is proposed that the bank be located at the Elyria Memorial Hospital and that it will be under the direct control of the society. The Medical Society's Committee includes: Dr. John Sullivan, Elyria, chairman; Dr. Swen Neilsen, Elyria; Drs. Robert Stack and John B. Donaldson, Lorain; Dr. R. W. Bradshaw, Oberlin; Dr. Francis Merritt, Amherst; and Dr. Stanley J. Birkbeck, Elyria, and Dr. L. H. Trufant, Oberlin, president and secretary, respectively, of the Lorain County Medical Society.

\* \* \*

Dr. Christopher G. Parnell, Rochester, N. Y., medical director of the Rochester General Hospital, has been engaged as hospital consultant by the Board of Governors of the Dettmer Hospital to be constructed in Miami County, from funds bequeathed to the county by a former resident. Widely experienced as a medical consultant on hospital service and hospital planning, Dr. Parnell last year was director of a commission appointed by Governor Dewey to investigate the entire state hospital system in New York.



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# In Memoriam

Mary Lantz Austin, M.D., Gallipolis; Ohio Medical University, Columbus, 1904; aged 78; former member of the Ohio State Medical Association and the American Medical Association; died May 21. Dr. Austin retired in 1938, after 33 years on the medical staff of the Ohio Hospital for Epileptics at Gallipolis. Formerly active in the Gallia County Medical Society, she had been chairman of the legislative committee, vice-president; and delegate to the Ohio State Medical Association.

Sylvanus S. Basinger, M.D., Elyria; Cleveland-Pulte Medical College, 1906; aged 67; member of the Ohio State Medical Association and the American Medical Association; died June 9. Acting city health commissioner, Dr. Basinger had practiced in Elyria since 1916. Previously he was located at New London. Dr. Basinger was a member of the Masonic Order and Odd Fellows Lodge. Surviving are his widow; two sons, including Lt. Norman Basinger, M.C., U.S.N.R.; and four brothers.

Russell Hall Birge, M.D., Cleveland; Harvard Medical School, Boston, 1898; aged 73; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Surgeons; died May 16. A former president of the Academy of Medicine of Cleveland and the Cleveland Medical Library Association, Dr. Birge had practiced there for over 40 years. He had been assistant clinical professor of surgery at Western Reserve University School of Medicine and during World War I was a major in the Army Medical Corps. Dr. Birge was a member of the Pasteur Club of Cleveland, Delta Upsilon and Phi Beta Kappa. His widow, a son, a daughter, a brother and two sisters survive.

Ellsworth T. Busching, M.D., Wyoming; Medical College of Ohio, Cincinnati, 1893; aged 78; died June 3. A native of Cincinnati, Dr. Busching practiced there until his retirement in 1921. He was a member of the Elmwood Place Board of Education and the Board of Health for more than 15 years. Dr. Busching was a Mason. Surviving are his widow and a son, Dr. Howard E. Busching, Wyoming.

Elizabeth Campbell, M.D., Cincinnati; Woman's Medical College, Cincinnati, 1895; aged 83; former member of the Ohio State Medical Association and the American Medical Association; died June 7. Dr. Campbell retired last February after an active professional career in Cincinnati. In 1902 she was elected to the staff of Christ Hospital, the first woman to hold such a position in a Cincinnati hospital. In 1910 she became vice-president of the Cincinnati

## DIED WHILE IN MILITARY SERVICE

Walter Frederick Henry Bartz, M.D., Youngstown; Ohio State University College of Medicine, 1939; aged 31; died October 24, 1944, while a prisoner of the Japanese. A captain in the Medical Corps of the Army of the United States, Dr. Bartz was taken prisoner when Corregidor fell in 1942. He was one of more than 1,775 prisoners who died as the Japanese were transferring them by ship from Manila to Japan last October. The ship was torpedoed 200 miles out in the China Sea and only nine survived. Dr. Bartz was called to active duty in May, 1941, following internship at Youngstown Hospital. Two months later he went to the Philippines.

nati Academy of Medicine, the first woman to hold that position. Dr. Campbell was the first president of the Cincinnati Visiting Nurse Association and the Cincinnati Social Hygiene Society. A national director of the Committee on Maternal Health, she was on the board of the American Social Hygiene Association for 11 years. In 1942 Dr. Campbell was elected an honorary member of the association, the third person to be so honored. A sister and a brother survive.

Barcomb Lanier Chipley, M.D., Chillicothe; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1906; aged 62; member of the Ohio State Medical Association and the American Medical Association; died May 13. Superintendent of the Mt. Logan Sanatorium since April 1, 1943, Dr. Chipley had served as resident chest surgeon at Johnson City, Tenn., government hospital for five years; one year each at Waverly Hills Sanatorium, Louisville, Ky.; Arkansas State Sanatorium; Hot Lakes Sanatorium, Hot Lakes, Oreg.; Ohio State Sanatorium, Mt. Vernon. He was then senior resident surgeon at Valley View Sanatorium, Patterson, N.J., for 12 years, and for the year prior to going to Chillicothe, was resident surgeon at the State Sanatorium, State Park, N.C. Dr. Chipley was a member of the Episcopal Church, Masonic Order, Elks, Eagles, Rotary Club, and the American Legion, having been an officer in the Army Medical Corps during World War I. Surviving are his widow and a son.

Harold Thompson Clapp, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1890; aged 77; died May 27. Dr.



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Clapp retired two years ago, after having practiced in Cleveland for over 50 years. He was a member of the Sons of the American Revolution and the Society of Mayflower Descendants. A daughter survives.

Howard Hubbell Davis, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1910; aged 62; member of the Ohio State Medical Association and fellow of the American Medical Association; died May 29. Dr. Davis practiced in Cleveland for 35 years. A captain in the Army Medical Corps, assigned to the British Expeditionary Force in France, he is reported to have been the first American soldier to win the Distinguished Service Cross in World War I. Dr. Davis was a member of the staff of Grace Hospital, and a member of Phi Gamma Delta and the Masonic Order. His widow survives.

Alfred Eugene Ewing, M.D., McDonald; Cleveland Medical College, Homeopathic, 1896; aged 76; member of the Ohio State Medical Association and the American Medical Association; died May 23. Dr. Ewing had practiced in the McDonald-Girard area of Trumbull County since 1918, when he moved to McDonald from Latrobe, Pa. Active in civic affairs, Dr. Ewing was a member of the Methodist Church; president of the McDonald Board of Education; director of the First National Bank, Girard, and a member of the Masonic Order, Odd Fellows Lodge and the Kiwanis Club. His widow, two sons and two daughters survive.

Smith Gorsuch, M.D., Castalia; Ohio Medical University, Columbus, 1902; aged 76; member of the Ohio State Medical Association and fellow of the American Medical Association; died May 23. Dr. Gorsuch practiced in Castalia and Erie County for 43 years. He was president of the Castalia Bank; a member of the Sandusky Chamber of Commerce and the Masonic Order. Surviving are his widow, a son, two daughters, two sisters and two brothers.

Loren Ervin Grimes, M.D., Zanesville; Ohio State University College of Medicine, 1914; aged 58; member of the Ohio State Medical Association and fellow of the American Medical Association; died June 7. Dr. Grimes practiced in Zanesville until ill health forced his retirement nine years ago. He was a former secretary-treasurer and vice-president of the Muskingum County Academy of Medicine. Dr. Grimes was a member of the Methodist Church, the Masonic Order and the Elks Lodge. His widow, a daughter, a sister and three brothers survive.

William C. Marshall, M.D., Yellow Springs; Medical College of Ohio, Cincinnati, 1890; aged 86; member of the Ohio State Medical Association and fellow of the American Medical Association;

died May 31. A former president of the Greene County Medical Society, Dr. Marshall practiced in Yellow Springs for about 20 years. From 1932 to 1936 he was county health commissioner. Dr. Marshall first practiced in Yellow Springs, later in Dayton for 15 years. In 1918 he moved to Selma, Clark County, and after a short time there, located in Springfield, where he practiced for three years. He returned to Yellow Springs 20 years ago. Two sons survive.

John Tipton McVey, M.D., Bremen; Ohio State University College of Medicine, 1913; aged 62; member of the Ohio State Medical Association and the American Medical Association; died June 8. A former vice-president of the Fairfield County Medical Society, Dr. McVey had practiced in Bremen since 1924. He formerly served on the staffs of the Ohio Hospital for Epileptics, Gallipolis, and the Massillon State Hospital. His widow, a son and a sister survive.

John Wilson Moffatt, M.D., Marietta; Starling Medical College, Columbus, 1891; aged 80; died June 8. Dr. Moffatt practiced in Mt. Gilead until 1916. He was at one time located in Belmont County. Surviving are a son, brother and a sister.

Nettie A. Belau Moss, M.D., Detroit, Mich.; Ohio Medical University, Columbus, 1896; aged 71; died May 25. Dr. Belau practiced in Defiance prior to going to Detroit in 1918. Her husband, a brother and a sister survive.

Cyrus W. Noble, M.D., Toledo; Eclectic Medical College, Cincinnati, 1897; aged 72; died May 29. Dr. Noble practiced in Cleveland for 35 years. He was previously located in Hoytville, Wood County. Dr. Noble was a past commander of the Knights of Pythias and a member of the Masonic Order. His widow, a daughter, a brother and three sisters survive.

John Albro Sipher, M.D., Norwalk; Western Reserve University School of Medicine, 1903; aged 72; member of the Ohio State Medical Association and the American Medical Association; died June 4. A former president of the Huron County Medical Society, Dr. Sipher had practiced in Norwalk for over 40 years. During World War I he was a captain in the Army Medical Corps, retiring from the Reserve Corps as a lieutenant-colonel in 1942. Dr. Sipher was a member of the Episcopal Church, the Masonic Order, Beta Theta Pi and Phi Beta Kappa. Surviving are a daughter, a son and a sister.

Clarence C. Weist, M.D., Columbus; Starling Medical College, Columbus, 1898; aged 68; died June 13. Dr. Weist retired two years ago, after having practiced in Columbus for 45 years. His widow, a daughter and a brother survive.



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# Examinations for License in Ohio Taken by 278 Medical School Graduates; List of Questions Asked by Board

**L**ICENSES to practice medicine and surgery in Ohio were sought by 278 medical school graduates at the examinations of the State Medical Board held in Columbus, June 18-21. Of these, 73 were graduates of Ohio State University College of Medicine; 73, University of Cincinnati College of Medicine; 87, Western Reserve University School of Medicine, and 45 from out-of-state medical schools.

Twenty-four applicants were examined in osteopathic medicine and surgery. In addition, 36 osteopaths, previously licensed in Ohio, sought license under the provisions of Sub. H. B. 112, which has been in effect since July 30, 1943. Examinations for certificates of limited practice were taken by 10 chiropractors, 11 mechanotherapists, 3 chiropodists, 16 masseurs and 14 cosmetic-therapists.

Results of the examinations will be announced by the Board at a meeting to be held in Columbus, July 30-31.

Following are the written questions asked those who were examined for licenses to practice medicine and surgery:

## ANATOMY

1. Name the structures which may be examined by palpation through the vagina, and give their relative position to same.
2. What structures are liable to injury when operating on mastoid cells. Where are these structures found in relation to the mastoid? What complications sometimes follow this operation and why?
3. Name the muscles which act upon the scapula, and give movement produced by each.
4. Give origin and distribution of the three large cerebral arteries.
5. Describe the arrangement of the blood vessels in the axilla.

## PHYSIOLOGY

1. (10 points.) What are the factors maintaining arterial circulation?
2. (10 points.) Describe ovulation, giving its relation to menstruation.
3. (10 points.) What are the principal features of a simple myogram; of an encephalogram?
4. (10 points.) Describe Wallerian degeneration and regeneration.
5. (10 points.) Give the events, in the order in which they occur, during a single cardiac cycle.
6. (10 points.) Describe three theories as to the cause of sleep. What physiological changes occur during sleep?
7. (20 points.) Define:
  - (a) Visual accommodation
  - (b) dirotic pulse
  - (c) thrombosis
  - (d) insemination
  - (e) lordosis
  - (f) arterial pulse
  - (g) catabolism
  - (h) hyperpnea
  - (i) peristaltic wave
  - (j) Chayne-Stokes respiration
8. (20 points.) What is the function of:
  - (a) the pericardium
  - (b) the eye brow
  - (c) the fontanelles of the skull
  - (d) the lachrymal ducts
  - (e) Glisson's capsule
  - (f) Islands of Langerhans
  - (g) kidney pelvis
  - (h) Meibomian glands
  - (i) sudoriferous glands
  - (j) reticular tissue.

## BACTERIOLOGY

1. Give the technic of laboratory diagnosis of typhoid fever; (a) serologic; (b) by culture.
2. Name two bacterial diseases which may be contracted from contaminated water or milk and give methods of detecting such contaminated supplies.
3. State the etiology of typhus fever, giving morphologic and cultural qualities of the bacterium.
4. Name three skin tests commonly used for diagnosis in infectious diseases. Give technic in each and describe positive and negative reactions.
5. Name four infectious diseases against which our troops are immunized and discuss materials and methods employed.

## DIAGNOSIS

1. Differentiate symptoms and physical findings of acute rheumatic fever and rheumatoid arthritis, with end results of both conditions, untreated.
2. Define acute hepatitis, obstruction of common duct, and give physical findings.
3. Differentiate finding in acute bursitis at deltoid attachment and brachial neuritis.
4. Give blood findings in chronic benzene poisoning and compare with so-called Bantist's Disease.
5. What do you understand by Rh. factor?
6. Give symptoms of so-called spastic colitis and usual cause.
7. If there is any difference in pleuritic fluid which you may find in cancer of lung, tuberculosis of lung and acute streptococcic hemolytic infection of lung—name such differences as to color and constituents.
8. In what general or special diseases do you find achlorhydria?
9. Give symptoms of so-called gastro-intestinal flu and diverticulitis. Differentiate.
10. Differentiate Vincent's infection of mouth and throat from acute streptococcic infection.

## CHEMISTRY

1. Distinguish threshold from non-threshold substances in the urine.
2. What is the chemistry of muscular contraction? How is it affected by adrenalin? By insulin?
3. Describe the gastric and intestinal digestion of fat, naming the enzymes involved.
4. How do you test for acetone bodies? What is their chemical and clinical significance?
5. Give the normal range of the CO<sub>2</sub> combining power of blood plasma.

## MATERIA MEDICA AND THERAPEUTICS

1. What symptoms would indicate the therapeutic effect of digitalization in a case of congestive heart failure and auricular fibrillation?
2. Aside from diabetes, in what other conditions is insulin employed?
3. Explain the emetic action of (a) ipecac (b) apomorphine hydrochloride.
4. Explain the action of (a) ammonium chloride (b) ammonium carbonate.
5. Classify diuretics and give an example of each class with dose of an official preparation.
6. Name the active principles of (a) belladonna (b) nuxvomica (c) cinchona (d) ipecac.
7. Give symptoms of poisoning by arsphenamine and its treatment.
8. Compare the effects of penicillin and sulfadiazine, with indications for use, giving doses and manner of administration of each.
9. Give antidote for poisoning by (a) opium (b) strychnia (c) arsenic (d) lead.
10. Atabrine—give its dosage and indications for use.

## MATERIA MEDICA AND THERAPEUTICS

### (Homeopathic)

1. What is meant by "potentization" in Homeopathy? What advantages are gained by potentization?
2. Give characteristic symptoms to indicate the prescription in acute bronchitis of (a) hepar sulph. calc.; (b) causticum; (c) antimonium tartaricum; (d) phosphorus.
3. Differentiate between (a) cantharis; (b) pulsatilla; and (c) mercurius corr. in cystitis.
4. Give characteristic symptoms indicating the prescription of (a) aconite; (b) euphrasia; (c) camphor; (d) nuxvomica in acute rhinitis.
5. Differentiate the skin lesions indicating the use of (a) arsenicum alb.; (b) graphites; (c) calcarea carb.; (d) ledum palustre.



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6. Give five remedies and their characteristic indications for use in parotitis (mumps).
7. Compare digitalis and strophanthus in heart conditions.
8. Give at least three indicating symptoms for each of four remedies in arthritis.
9. In colitis, compare the indicated use of mercurius corr., ipecacuanha and nux vomica.
10. Compare the mental symptoms of (a) aconite; (b) gelsemium; and (c) hyoscyamus.

#### PRACTICE

1. Discuss poliomyelitis—supposed etiology; transmission; symptoms, early and late; and treatment.
2. Give the symptoms and treatment of sub-acute bacteriological endocarditis.
3. Discuss the etiology, symptoms and treatment of (a) type 1 pneumococcic pneumonia and (b) atypical virus pneumonia.
4. Give the etiology, symptoms and treatment of acute chorea.
5. What is meant by food allergy? Give three examples, methods of recognition and procedures of correction.

#### PATHOLOGY

1. A patient presents enlarged glands of the neck. Name four possibilities and give the differential pathology.
2. Name two possible causes of free hematemesis and give the pathology of each.
3. Discuss the pathology of myeloid leukemia.
4. Discuss the pathologic findings often present in sand dust workers and their relation to secondary conditions which may develop.
5. In a post-operative case, a patient complains of severe pain in the chest, respiratory distress and evidences of shock are present. If the patient dies, give the probable autopsy findings; if he survives, discuss the probable pathologic changes occurring.
6. Discuss the common pathology resulting from gonorrhea in the female.
7. Discuss the pathology of two conditions causing esophageal obstruction.
8. Discuss the pathology of prostatic enlargement and the consequences in (a) benign enlargement and (b) malignant enlargement.
9. What is meant by metastasis in malignancy? Give three examples.

10. Discuss the pathology present in a case of moderate unilateral pulmonary tuberculosis.

#### SURGERY

1. Discuss regional ileitis, particularly from the standpoint of symptoms and surgical treatment.
2. Discuss deep cervical suppuration under the headings: (a) etiology (b) zones of spread (c) choice of anaesthetic (d) surgical treatment.
3. Discuss the treatment of fracture of the surgical neck of the humerus.
4. What are the possibilities of the use of penicillin in Forward Base Hospitals, giving indications and dosage?
5. Discuss the treatment of gunshot wounds of the abdomen.

#### OBSTETRICS AND GYNECOLOGY

1. Discuss the use of ergot and pituitrin in obstetrics.
2. Give diagnosis and management of breech presentation.
3. Describe the pelvic straits.
4. Discuss blood pressure in obstetrics.
5. Give etiology and symptoms and treatment of puerperal infection.

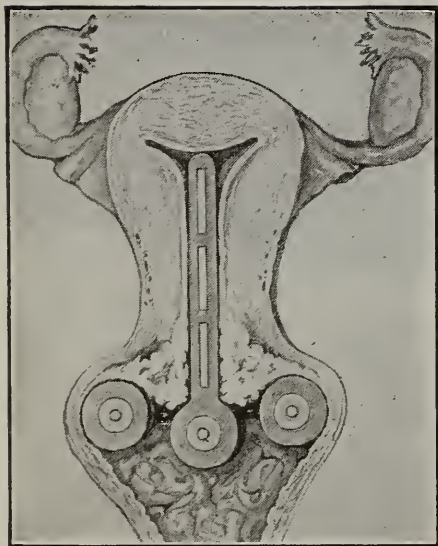
#### SPECIALTIES

1. Give symptoms and treatment of scarlet fever.
2. Differentiate tonsillitis and diphtheria.
3. What are the early signs and symptoms of dementia praecox?
4. Give symptoms and treatment of herpes zoster.
5. Define and give cause, diagnosis and treatment of glaucoma.

#### PREVENTIVE MEDICINE

1. Assume that you have been employed as Health Commissioner of a district having 10,000 to 25,000 inhabitants and your Board has asked you to present an adequate public health program for the District. Write out such a program.
2. Give points of diagnosis of hook-worm infestation and outline measures to be instituted for its prevention.
3. What measures should be taken to prevent and/or eradicate typhoid fever in a community?
4. Give a complete anti-tuberculosis program.
5. Name five diseases for which there are today acceptable methods of immunization. What are the tests of immunization against the diseases named?

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# Industrial Commission Report on Claims Shows Causes of Accidents and Nature of Injuries in Year 1943

**S**TATISTICAL report issued by the Ohio Industrial Commission for the calendar year 1943, based on data assembled by the Division of Safety and Hygiene, shows that 328,121 accident and occupational disease claims were filed with the Commission during that year, in contrast to 159,248 claims filed in 1934, the first year of that particular 10-year period.

Of the 328,121 claims filed, 1,104 were for fatalities; eight for permanent total disability, 2,797 for permanent partial disability, 46,604 for temporary disability over seven days, 25,860 for temporary disability of seven days or less and 251,748 for temporary disability which resulted in no time loss. The days lost through disabilities totaled 10,106,407.

## PRINCIPAL CAUSES OF ACCIDENTS

In 1943 the six principal agencies causing industrial accidents in the order of their standing were: machinery, 72,601 claims with 44 fatalities; hand tools, 34,283 with 13 fatalities; metal stock (not otherwise listed), 34,487 with 11 fatalities; bundles, barrels, boxes, benches, etc., 21,707 with 18 fatalities; flying objects, dust, cinders, etc., 16,433 with no fatalities; pipes, rods, sheets or plates, 17,173 with 12 fatalities.

Other accident causes shown in the study, their contributions to accident frequency and the number of fatalities charged to them, are as follows:

Elevators, 992 with 12 fatalities; hoisting apparatus, 1,944 with 31 fatalities; motor vehicles,

7,253 with 116 fatalities; other vehicles, 9,254 with 77 fatalities; electrical apparatus, 1,645 with 33 fatalities; chemicals 5,865 with 51 fatalities; highly inflammable and hot substances, 10,151 with 47 fatalities; coal, 1,531 with 35 fatalities; roads, sidewalks and floors, 10,948 with 23 fatalities; platforms, scaffolds and stairs, 5,283 with 37 fatalities; bricks, rocks and stones, 3,258 with seven fatalities; glass, 665 with no fatalities; castings, 5,233 with two fatalities; doors, windows and gates, 3,030 with two fatalities; frames, models and forms, 3,197 with seven fatalities; ladders, 2,115 with 12 fatalities; lumber or wood-working material (not otherwise classified), 7,027 with six fatalities; nails, spikes, tacks, etc., 5,279 with one fatality; wires (not electrical), 2,534 with no fatalities; occupational diseases, 7,156 with 114 fatalities; all other agencies 32,097 with 391 fatalities.

As usual, lacerations furnished the basis for more occupational injury claims than any other

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form of injury. The year 1943 was no exception in the long list of years during which this nature of injury has been outstanding. Lacerations gave rise to 95,765 claims; contusions 63,249; foreign body 35,852; sprains and strains 41,585; punctures 36,973; traumatic amputations 1,533; asphyxiations 206; dislocations 741 and unclassified 5,820. These various injuries have held the same relative position in the order of the frequency of their occurrence ever since the assembling of statistics was begun.

Frequency with which the hands of workers are used in industrial operations, has caused the fingers to suffer more often than any other part of the body. The record shows that in 1943, a total of 80,283 claims were filed for finger injuries. Eye injuries were next with 72,368, the trunk had 41,950, legs 29,749, arms 31,532, hands 23,635, head and face 18,516, feet 16,648 and toes 13,400. The traumatic amputations reported represent the loss of 18 arms, seven hands, 1,460 fingers, eight legs, one foot and 39 toes.

Included in the 19,836 fractures reported in 1943 were 85 of the transverse or spinous process, 271 of the vertebrae, 31 of the sternum, 1,557 of the ribs, 93 of the sacrum or coccyx, 170 of the pelvis, 343 of the skull, 204 of the nose, 102 of the jaw, 257 of the teeth, 1,843 of the arms, 801 of the hands, 5,262 of the fingers, 1,688 of the legs, 1,946 of the feet and 5,135 of the toes. The severity of injuries of this nature is shown by the fact that they caused a time loss to workers of 1,895,299 days.

### Medico-Legal Seminar

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University, in association with the Massachusetts Medico-Legal Society, will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety, October 1 to 6, inclusive. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend. Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

*Modern Hospital* has announced competition for an essay of 5,000 words or less on "A Plan for Improving Hospital Treatment of Psychiatric Patients". The top prize is \$500. Details of the contest can be obtained by writing The Modern Hospital Publishing Company, 919 N. Michigan Ave., Chicago 11, Ill. All essays must be received by October 1, 1945.

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## WAR NOTES

Lt. Col. Roy D. Arn, Dayton, has been decorated with the Bronze Star Medal for meritorious achievement in connection with military operations against the enemy in Leyte province, Philippine Islands, from Dec. 19, 1944 to Jan. 2, 1945. The citation reads in part as follows:

"Lieut. Col. Arn volunteered for temporary duty in support of a frontline unit despite the fact that such duty was not commensurate with his rank, age or assignment to a fixed base hospital.

"He found the unit after an arduous and dangerous three-day trip on foot over the most rigorous mountain terrain and immediately undertook the performance of major surgical procedures which resulted in the saving of many lives.

"He continued to render his services until the unit finished the combat operation. The enthusiasm manifested by Lieut. Col. Arn in volunteering for such an assignment and in the performance of fine surgical procedures which saved the lives of many men reflects great credit upon himself and the service."

\* \* \*

Lieut. (j.g.) Robert C. Gavin, Fond du Lac, Wis., who went on active duty Jan. 10, 1944, following the completion of an internship at the Cincinnati General Hospital, was drowned in the Asiatic Area, Dec. 18, 1944, when the U. S. S. Monaghan, a 1,300 ton destroyer, of which he was medical officer, and two other ships capsized in a typhoon that struck the carrier task force to which the three ships were assigned.

\* \* \*

Lieut. Burton V. Scheib, Toledo, is with the Marines on Okinawa.

\* \* \*

News about Columbus doctors from The Bulletin of the Columbus Academy of Medicine: Capt. Peter A. Volpe, "down but not out" from a mine explosion in Belgium, expects to be at Wakeman General Hospital for at least nine more months. . . . Lt. Col. Claude S. Perry, with the 76th General Hospital, near Liege, reports that "Cologne, like Aachen and Duren, is a mess". . . . Out in the Philippines is Capt. W. B. Andrus, as assistant chief of medicine and chief of the Tropical Disease Section, in a station hospital. . . . Lt. Comdr. Harve M. Clodfelter, "having a fairly good service in medicine on a small rock in the Western Carolines". . . . Capt. O. L. Coddington, deep in Germany late in April,

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**OBSTETRICS**—Two Weeks Intensive Course Oct. 8.

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"hoping hourly for a link up with the Russians". . . Maj. Dan Morse, home-town visitor en route to his new station at Fitzsimmons General Hospital, Denver. . . Another Columbus visitor, Major Lovell W. Rohr, of Camp Sheppard, Wichita Falls, Texas, serving his second hitch of war duty, having been in France during World War I. . . Assistant chief of surgery with the 106th Evacuation Hospital, Capt. Walter Stout, followed the famous Fourth Armored Division across France and also has seen a lot of Luxembourg, Belgium and Germany. On Easter Sunday, while on reconnaissance for a new hospital site, with his Colonel and three other officers, he was ambushed and captured by the remnant of an S. S. Division that had been cut off by advancing American troops. Fortunately the group was released by our own troops after having done surgery for 12 hours "under the protection of the Third Reich". Capt. Stout considers himself lucky to have gotten out of the affair with only a minor hand wound.

\* \* \*

The Combat Medical Badge has been awarded Maj. John J. Gallen and Capt. Ralph L. Phillips, Columbus, who are in the thick of it with Ohio's 37th Division in the Philippines.

\* \* \*

Capt. Samuel K. Gerson, Lancaster, assistant wing surgeon for a Fighter Wing in Italy, was formerly with a night fighter squadron. He went overseas more than two years ago, and has had many interesting experiences in England, Africa, Sicily and Italy.

\* \* \*

After two years and 10 months in the service, Maj. J. Paul McAfee has been honorably discharged. He expects to reopen his office in Portsmouth after a postgraduate course in pediatrics and obstetrics. Dr. McAfee was first stationed at the Air Transport Command base at Detroit, after which he was sent to an air service command base at Fresno, Calif., where he remained for two years. His final four months in the Army was served at Kelley Field, Tex.

\* \* \*

Comdr. W. H. Perry, Cleveland, chief of E.E.N.T., at the U. S. Naval Hospital, Chelsea, Mass., has been in sick bay himself, following the removal of his gall bladder. He was in the South Pacific 20 months (Munda, Fiji Islands and New Georgia) as executive officer of a base hospital.

\* \* \*

New locations "state-side": Maj. Jack A. Adelman, Columbus, Rosencrans Field, St. Joseph, Mo.; Lt. Comdr. C. F. Ward, Cleveland, A.B.A.-T.U., Naval Training Center, Fleet Hospital No. 12, Lido Beach, Long Island, N.Y.; Maj. R. W. Weiser, Cincinnati, Hdqrs. Sec., M.D.E.T.S., Camp Atterbury, Ind.; Lt. Comdr. H. B.

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Lt. Col. John E. L. Keyes, Youngstown, Reg. Hosp., Camp Swift, Texas; Lieut. S. L. Burkhardt, Steubenville, U.S.N. Rec. Sta., Detroit, Mich.; Lt. Comdr. J. C. Blagdon, Cleveland, Naval Medical Center, Bethesda, Md.; Maj. Glenn H. Walker, Woodville, Manhattan, Kans.; Maj. Robert J. Tapke, Cincinnati, Nichols Gen. Hosp., Louisville, Ky.; Capt. S. J. Shapiro, Warren, Sta. Hosp., Camp Reynolds, Pa.; Lt. Col. Chas. J. Prochaska, South Euclid, Sta. Hosp., Tyndall, Field, Panama City, Fla.; Maj. Clark Pritchett, Columbus, Dept. of Patients, Reg. Hosp., Patterson Field, Fairfield, Ohio; Capt. Paul D. Meyer, Cleveland, Army School of Roentgenology, University of Tennessee, Memphis, Tenn.; Capt. S. L. Meltzer, Portsmouth, Hammond Gen. Hosp., Modesto, Calif.; Maj. Paul McConnell, Youngstown, Hq., 7th Service Command, Omaha, Nebr.; Maj. Elmer C. Loomis, Dayton, 1079 A.A.F.B.U., Conv. Hosp., Camp Davis, N.C.; Lt. Howard F. Kuhn, Cincinnati, U.S.N. Conv. Hosp., Sun Valley, Ketchum, Idaho; Maj. William J. Horger, East Liverpool, Crile Gen. Hosp., Cleveland; Capt. A. F. W. Helmbold, Cincinnati, Oliver Gen. Hosp., Augusta, Ga.; Capt. Joseph M. Gledhill, Warren, Percy Jones Gen. Hosp. Annex, Battle Creek, Mich.; Lt. Comdr. R. R. Crawford, Mansfield, U.S. Naval Hospital, Bainbridge, Md.; Lt. Comdr. L. E. Kroger, Hamilton, A. & R. Dispensary, N.A.S., Corpus Christi, Tex.; Capt. R. M. Zofikoff, Mariemont, Fletcher Gen. Hosp., Cambridge.

\* \* \*

Wearer of the Bronze Star Medal and the Purple Heart, Capt. James B. Johnson, Jr., Newark, has been with the 1st Cavalry Division since entering Army service in 1942. He was last reported to be on Luzon in the Philippine Islands.

\* \* \*

Capt. J. F. Hattenbach, with a bomb group in Italy, and overseas for 27 months, sends the good word that future issues of *The Journal* should go to his home in Rocky River, and that while he has certainly appreciated *The Journal* over there in Italy, he'll be much happier to read it in Ohio.

\* \* \*

The 1945 membership card of Lt. Wm. A. Nosik, Cleveland, did not reach him until May 20—and no wonder! After being with the Marines at the capture of Saipan last year, he was

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\*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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★

★

transferred to an assault hospital ship and "made" D-days at Leyte, Lingayen, Kiramo Retto, Okinawa and Iwo Jima! He received the Philippine Liberation ribbon with two stars. Dr. Nosik is quite the old "shell-back", having crossed the equator eight times, all in forward war zones. Recently transferred back to the Marines, with an evacuation hospital, he is doing a lot of neurosurgery.

\* \* \*

The Bronze Star Medal has been awarded to Maj. Dorrance S. James, Delaware, with the 11th Evacuation Hospital, last reported to be in the vicinity of Hamburg, Germany. According to the citation, Maj. James displayed "sound surgical judgment, initiative and tact in coordinating and supervising post-operative care of 4,072 operative surgical cases. Through his conscientious attention to his duties, Maj. James was instrumental in saving many lives and his service is in keeping with the highest traditions of the military service." The service for which the award was made covered the period from November 11, 1944 to May 6, 1945.

\* \* \*

After a little over a year as flight surgeon with the B-29's in India and China, Capt. H. Roenigk, Cleveland, moved over recently to an Island in the Pacific. He comments: "The heat is much less terrific here and it is cool enough to sleep at night, which is something. Food also is improved. We get ham and pork chops and even apples from the States. After India, that is a treat."

Some enterprising censor chopped up Capt. Roenigk's letter, but the following additional observation is salvaged: "When they tell you those cities are burning down, you can believe it. You see one tremendous area belching puffs of smoke, with flames and explosives dispersed throughout." Sounds like the flight surgeon went along on one of the B-29 trips to Japan.

\* \* \*

Awarded the Bronze Star Medal for his work with a medical clearing company during the Battle of the Bulge last Winter, Capt. Jerome Fisher, Columbus, reports that he is right busy now helping to take care of "thousands of people in concentration camps, with every known medical ailment".

\* \* \*

Maj. Max T. Schnitker, Toledo, has joined the Ohio contingent in India. He is doing neurosurgery in a large general hospital.

\* \* \*

After traveling all over the Pacific on sea duty, Lt. Comdr. Harve M. Clodfelter, Columbus, was flown 5,000 miles in about 28 hours to his present post—a Naval base hospital, about which he has this to say: "This spot on a small rock

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| THROAT CULTURES        |   | PREGNANCY TESTS       |
| STOMACH CONTENTS       |   | BASAL METABOLISM      |
| SURGICAL PATHOLOGY     |   | PNEUMOCOCCIC TYPING   |
| AGGLUTINATION TESTS    |   | AUTOGENOUS VACCINES   |
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out in the huge Pacific is really a big chunk of coral. It has quite a history behind it and will be the basis of some mighty good movies in years to come. The hospital is made up of Quonset huts; plenty of cocoanut trees, a good sandy beach, plenty of heat but fairly good food, ice and Coca Cola. Our whiskey is rationed and costs \$1.50 per fifth, and cigarettes are the usual five cents per pack . . . The good old *Journal* is a welcome sight. It gets in a little late, but am getting used to late journals and magazines. The air mail service is really one of the wonders of this war. I saw a mail plane land on Okinawa with mail for the fighting marines on the second afternoon of the invasion, with mail less than four days old from home."

\* \* \*

Maj. John E. Martin, Columbus, assistant flight surgeon at the Eighth Air Force, Third Division headquarters, has received the Bronze Star Medal for meritorious service.

\* \* \*

Lieut. A. M. Shrader, recently returned from duty with the Navy in the Pacific, gave the Memorial Day address in his home-town, Waverly.

\* \* \*

After 34 months with the Fourth General Hospital in Australia and New Guinea, Capt. E. C. Weckesser, Cleveland, is home on rotation, and has been assigned to the surgical staff at Crile General Hospital.

\* \* \*

Maj. William F. Ashe, Jr., Cincinnati, now on duty in the Office of The Surgeon General, spoke on "Nutrition in the Army", at the Food Service Conference of the Transportation Corps at the New Orleans P.O.E. recently. The conference was attended by representatives of all the Ports of Embarkation, Office of the Chief of Transportation, Office of the Quartermaster General, and by the Food Service Supervisors of the Nine Service Commands.

\* \* \*

Maj. O. D. Ball, New Lexington, and Capt. W. G. Meyer, Columbus, are in the same field hospital unit in Okinawa.

\* \* \*

After 29 months in Alaska, Capt. L. Dow Allard, Portsmouth, has been assigned to duty at Vancouver Barracks, Vancouver, Wash.

\* \* \*

Maj. Jack A. Rudolph, Columbus, chief of the Allergy Section, Oliver General Hospital, Augusta, Ga., was recently certified by the American Board of Internal Medicine.

\* \* \*

According to the Technical Information Division, Office of The Surgeon General, Dr. John Romano, professor of psychiatry, University of Cincinnati College of Medicine, was one of five prominent civilian psychiatrists who

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toured all Army headquarters installations in Europe recently to study the psychological factors in the combat infantry soldier and methods of psychiatric treatment now in use. It is expected that they will make recommendations on the correlation of the methods of treatment and the mental attitudes of battle-weary soldiers. The group left for the E.T.O. on April 20, under the auspices of the Office of Scientific Research and Development. They were scheduled to return on June 15.

\* \* \*

Lt. Comdr. Wallace B. Taggart, Dayton, senior medical officer of a 100-bed dispensary on Luzon, ran across Maj. Frank Vecchio, Cleveland, and has heard that Maj. W. R. Hochwalt and Lt. Col. Roy Arn, Dayton and Col. David Chambers, Cleveland, are not too far away, but so far he has had no opportunity to meet them. Dr. Taggart passes on this hopeful comment: "On my way and since landing I have had impressed on me the tremendous weight of power and men our Navy and Army have assembled to soon crush resistance from Japan. One never realizes it until you have had the chance to see it first-hand."

\* \* \*

Maj. Walter G. Engel, Cincinnati, finds life more comfortable since he arrived in Manila from New Guinea. His general hospital is set up in two college buildings, with beautiful grounds, a swimming pool and showers. The staff is kept busy with an endless variety of medical cases, and regular medical society meetings are held weekly. Maj. Engel says one of the most interesting sights out there is the "magnificent Lake Taal, a volcanic lake thousands of feet below the rim". Maj. John Borelli, Hamilton, and Maj. Asher Randall, Youngstown, are also on the hospital staff. (If you want to have an Ohio reunion, Capt. Henry Bachman and Lt. Kendall O. Kennedy, both of Delaware, are reported to be in Manila, Capt. Bachman with another general hospital, and Lt. Kennedy with the First Filipino Regiment.)

\* \* \*

More "state-side" changes of location: Maj. Robert E. Wolfe, Uhrichsville, M.D.R.P., Carlisle Barracks, Pa.; Capt. Horace G. Mabee, Cleveland, Vet. Adm. Fac., Fort Custer, Mich.; Lt. Comdr. Thomas F. Charvat, Cleveland, U.S.N. Hosp., Fort Eustis, Va.; Capt. T. L. Light, Dayton, Sec. B, 110 A.A.F.B.U., Mitchell Field, Long Island, N.Y.; Capt. J. B. Rayman, Toledo, Miami Beach, Fla.; Maj. L. K. Reed, Youngstown, 307th Gen. Hosp., Ft. Benning, Ga.; Capt. Gilbert E. Garvin, Blanchester, Chicago, Ill.; Capt. J. D. Swango, Waterloo, Ashford Gen. Hosp., White Sulphur Springs, W. Va.; Capt. R. L. Wiesinger, Sidney, Air Evac. Unit, Sta. Hosp., A.A.B., Stockton, Calif.; Maj. Myron Freilich, Squadron B, A.A.B., Columbia, S. C.; Capt. R. G.

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on Foods

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\* \* \*

Maj. William Dreyfuss, Cleveland, reports quite a colony of Ohio medical officers in the 178th General Hospital, of which he is chief of G. U. surgery. They are: Capt. Myron Crawford, Cleveland, chief of the shock ward and rehabilitation; Lt. Lewis W. Whiting, another Cleveland, in the orthopedic department; Capt. Rich Werscott, Cincinnati, chief of cardiology; Capt. Sidney Davidow, North Jackson, in the medical department and transportation officer. The unit went to England last Fall, and shortly thereafter moved across the Channel to France. It is now located in Reims, France.

\* \* \*

With the 130th Evacuation Hospital in Mauthausen, Austria, Maj. Wendell M. Steele, Newark, adds his voice to those of other doctors "who cry out from the wilderness against the Wagner-Dingell Bill". He writes: "The medical officers overseas ask that action on this bill be postponed until we return to the States. We do not want this legislation pressured through as was the Volstead Act during World War I."

\* \* \*

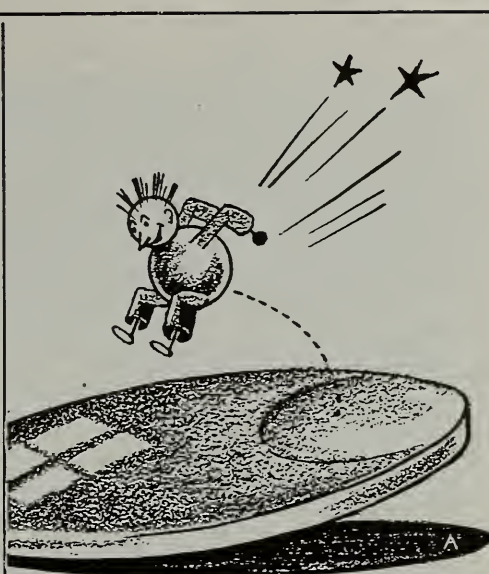
Lt. Col. Arthur G. King, Cincinnati, recently assigned as chief of Women's Surgery at McCaw General Hospital, Walla Walla, Wash., reports that Major Ed Harper, Cleveland, is chief of neuropsychiatry.

\* \* \*

Rescue of a carrier pilot who misses the flight deck of a carrier produces "some exciting moments", writes Lt. M. P. Thomas, Cleveland, who has been at sea for over 10 months.

\* \* \*

Formerly on the staff of the 201st General Hospital in France, Maj. Paul E. Adolph, Bellevue, is now surgical consultant to eight German P.O.W. hospitals. He comments: "My contacts with the German doctors make me realize that they practice a different type of surgery from our American surgery. Nazi-ism seems also to have retarded their advance in some of the more recent developments."



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**ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE  
OHIO STATE MEDICAL JOURNAL FOR YEAR ENDED DECEMBER 31, 1944, BY  
KELLER, KIRSCHNER, MARTIN AND CLINGER, CERTIFIED PUBLIC  
ACCOUNTANTS, COLUMBUS, OHIO**

**OHIO STATE MEDICAL ASSOCIATION**

**Cash and Bonds on Hand January 1, 1944:**

|                                    |             |
|------------------------------------|-------------|
| Cash in bank .....                 | \$ 8,055.22 |
| United States Treasury Bonds ..... | 71,000.00   |

Total cash and bonds on hand, January 1, 1944 \$ 79,055.22

**RECEIPTS**

|                                                     |             |
|-----------------------------------------------------|-------------|
| Membership dues 1944 .....                          | \$34,836.00 |
| Exhibits, 1944 convention .....                     | 7,034.50    |
| National Tuberculosis Association .....             | 10.00       |
| Membership dues prior years .....                   | 14.00       |
| Pending credit .....                                | 1.50        |
| Balance of miscellaneous receipts .....             | .85         |
| Interest on U. S. Treasury Bonds .....              | 1,671.25    |
| Refund on telephone and telegraph<br>for 1944 ..... | 267.05      |
| Banquet tickets—1944 Annual Meet-<br>ing .....      | 1,048.00    |

Total cash received .....

44,883.15

Total To Be Accounted For .....

\$123,938.37

**DISBURSEMENTS**

|                                                                   |             |
|-------------------------------------------------------------------|-------------|
| Ohio State Medical Journal .....                                  | \$ 9,000.00 |
| Executive Secretary's salary .....                                | 6,800.00    |
| Executive Secretary's expense .....                               | 797.18      |
| Assistant Executive Secretary's salary .....                      | 5,300.00    |
| Assistant Executive Secretary's expense .....                     | 544.38      |
| President's expense .....                                         | 173.50      |
| Stenographer's salaries .....                                     | 4,210.00    |
| Council's expense .....                                           | 595.58      |
| Committee on Public Relations and Economics .....                 | 1,929.44    |
| Committee on Industrial Health .....                              | 800.00      |
| Committee on Education .....                                      | 26.50       |
| War Participation Committee .....                                 | 102.49      |
| Annual Meeting .....                                              | 3,775.63    |
| Miscellaneous Committee .....                                     | 200.00      |
| American Medical Association Delegates .....                      | 193.89      |
| Stationery and supplies .....                                     | 515.81      |
| Postage, telephone and telegraph .....                            | 1,147.59    |
| Rent .....                                                        | 2,400.00    |
| Auditing .....                                                    | 100.00      |
| Employees' bonds .....                                            | 20.81       |
| Industrial insurance .....                                        | 11.67       |
| Liability insurance .....                                         | 40.00       |
| Unemployment insurance .....                                      | 92.17       |
| Fire insurance .....                                              | 25.60       |
| Refunds of dues—military service and over-<br>payments .....      | 623.00      |
| Refunds—1944 exhibit space .....                                  | 210.00      |
| Refunds of dues—military service and overpay-<br>ments—1943 ..... | 43.50       |

Total disbursements .....

\$ 39,678.74

**Cash on Deposit and Bonds on Hand at December 31, 1944:**

The Huntington National Bank—Treasurer's ac-  
count .....

\$ 13,259.63

**U. S. Treasury Bonds:**

|                            |             |
|----------------------------|-------------|
| Series G—12 year 2½% ..... | \$40,000.00 |
| Issue of 1948-50 2% .....  | 25,000.00   |
| Issue of 1955-60 2⅞% ..... | 5,000.00    |
| Issue of 1959-60 2¾% ..... | 1,000.00    |

71,000.00

Total cash and bonds on hand Dec. 31, 1944 \$ 84,626.63

Total Accounted for .....

\$123,938.37

(1945 dues and exhibit rentals collected in 1944 but not  
included in accompanying statement .....

\$14,528.50)

**THE OHIO STATE MEDICAL JOURNAL**

**ASSETS**

**Current Assets, January 1, 1944:**

|                                   |             |
|-----------------------------------|-------------|
| Cash—The Ohio National Bank ..... | \$ 2,203.76 |
| Cash—Petty .....                  | 10.00       |

Total cash .....

\$ 2,213.76

Prepaid Annual Meeting expense .....

29.62

Accounts receivable .....

1,296.99

Total current assets .....

\$ 3,540.37

**Property Assets:**

Furniture and fixtures—depreciated value .....

2,370.81

Total Assets .....

\$ 5,911.18

**LIABILITIES AND SURPLUS**

**Current Liabilities:**

Subscriptions prepaid .....

\$ 150.00

**Surplus:**

Surplus at December 31, 1943 .....

\$ 6,111.05

Less net loss for the year 1944 .....

349.87

Surplus at December 31, 1944 .....

\$ 5,761.18

Total Liabilities and Surplus .....

\$ 5,911.18

**STATEMENT OF PROFIT AND LOSS**

**Revenue:**

Advertising .....

\$ 17,747.76

**Less:**

Commissions on advertising .....

\$ 1,303.34

Cash discounts .....

86.69

Total deductions .....

1,390.03

Advertising revenue—net .....

\$ 16,357.73

Circulation .....

9,960.65

Total revenue .....

\$ 26,318.38

**Expenses:**

Journal printing .....

\$16,644.54

Office salaries .....

5,457.00

Journal postage .....

633.63

Journal illustrations and engravings .....

162.99

Journal envelopes .....

1,136.40

Depreciation .....

247.43

Clipping service .....

120.00

Dues and subscriptions .....

101.90

Office supplies and expense .....

883.81

Membership subscriptions .....

600.00

Bad debts .....

16.00

Miscellaneous postage and expense .....

664.55

Total expenses .....

\$ 26,668.25

Net Loss .....

\$ 349.87

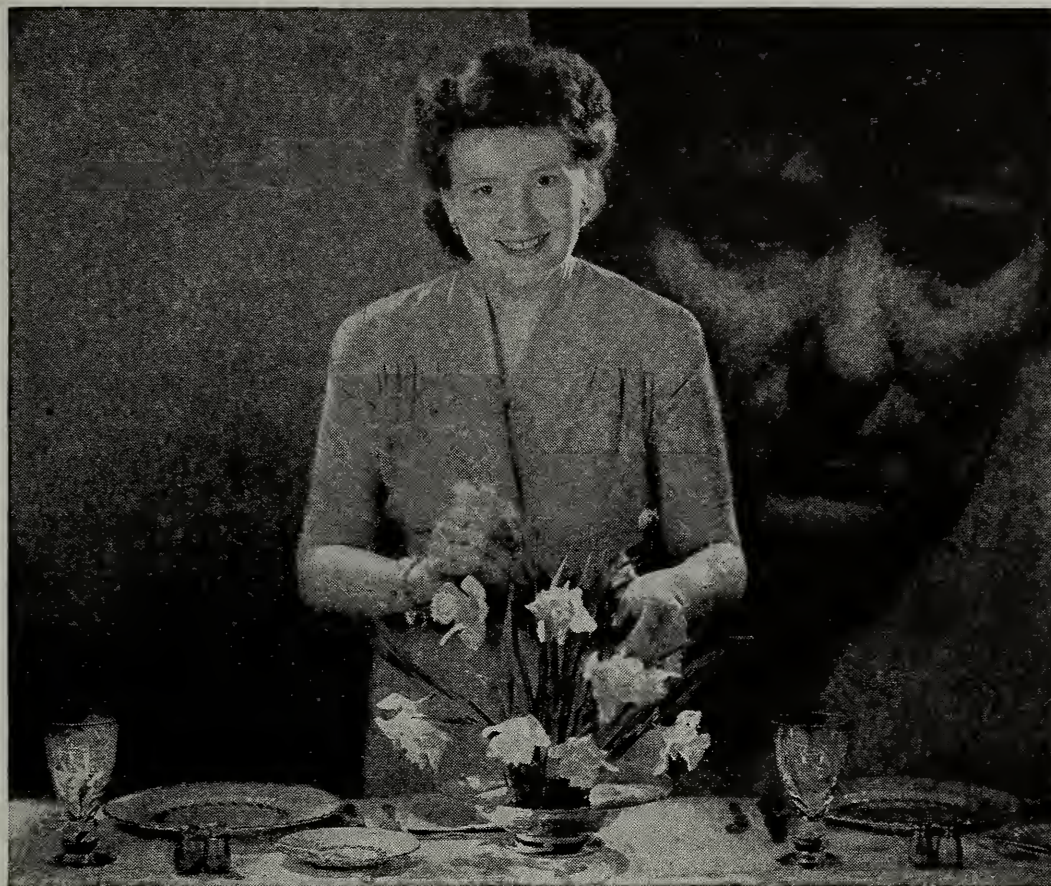
Cleveland—Speaking on "Truth in Medicine", Dr. John A. Toomey, Cleveland, warned members of the Knights of Columbus against exaggerated advertisements and spectacular reports of new miracles in medicine.

Gallipolis—Dr. Charles E. Holzer, president of the Ohio Valley Conservation and Flood Control Congress, presided at a recent meeting of the officers and committeemen of the organization here.

Dayton—Physicians of Montgomery County have accepted a quota of \$65,000 as their share of a campaign to raise \$1,100,000 to enlarge St. Elizabeth Hosiptal. Dr. R. S. Binkley is chairman of the Medical Division.

Lakewood—The City Council has employed Dr. Fred G. Carter, director of St. Luke's Hos-  
pital, Cleveland, as consultant on plans for the proposed enlargement of Lakewood Hospital.





## In the severe depressions of the menopause

Many women in the climacteric period develop a true reactive depression, characterized by apathy and despondency.

● This depressive syndrome is frequently progressive; and, unless promptly and effectively treated, may seriously impair the patient's normal capacity for useful living. While estrogenic therapy and other basic treatments can do much to relieve these sufferers, many need further help if a prompt recovery is to be obtained.

● In such cases, Benzedrine Sulfate helps to reawaken mental alertness and

optimism, and to restore the savor and zest of life.

● Obviously, Benzedrine Sulfate should not be used for the casual case of low spirits or normal physiologic depression as distinguished from true prolonged mental depression. Smith, Kline & French Laboratories, Philadelphia, Pa.



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**SULFATE**  
*Tablets* *Elixir*

(RACEMIC AMPHETAMINE SULFATE, S. K. F.)



# The Physician's Bookshelf

**A Synopsis of Medicine**, by Sir Henry Letheby Tidy, (\$7.50. 8th Ed., Revised and Enlarged. *The Williams & Wilkins Co., Baltimore*) has its value supported by the reception which it has received. The revisions this time have to do largely with the great advances that have been made since the appearance of the Seventh Edition in 1939. "Sulpha" drugs, pernicious anemia, and the Rh factor represent the larger of the new contributions.

**Conscience and Society. A Study of the Psychological Prerequisites of Law and Order** by Ranyard West, M.D., (\$3.00. *Emerson Books, Inc., New York City*) is a book full of unhampered and original thought which is most stimulating. It gives a reasonably complete discussion of the vital topic of how to live with ourselves and live acceptably with others. This, the biggest problem, for each individual, each state, finds here a blueprint for its resolution.

**What To Do About Vitamins**, by Roger J. Williams, Ph.D., (\$1.00. *University of Oklahoma Press, Norman, Okla.*) has been written for the laymen by the discoverer of pantothenic acid. Contrary to what you might guess, it is well done in a simple, clear fashion that is most helpful. A book that you can recommend on this popular subject about which there is about as much misinformation as there is information at the present time.

**Taxes Without Tears**, by Donald B. Marsh, (\$2.50. *The Jaques Cattell Press, Lancaster, Pa.*) it a subject which interests us all. Facing a generation of high taxes we all should become aware of the astonishing possibilities for good and evil that lies in the application of taxation for social ends. Taxes no doubt will make even more astonishing changes in our life than the inventions of science and so we ought to arm ourselves by reading books like this and the following one.

**Tomorrow's Business**, by Beardsley Ruml, (\$2.50. *Farar & Rinehart Inc., New York City*) outlines the views of the author of the pay-as-you-go income tax. It can be read with enjoyment and understanding by all, because of the many modern problems it considers.

**City Development. Studies in Disintegration and Renewal**, by Lewis Mumford, (\$2.00. *Harcourt, Brace & Co., New York City*) contains the author's most important essays on City Development. For 30 years, the author has studied and led in the field of city planning. In these days when our own city has a post-war planning commission it behooves us to read this book.

**Doctors at War**, edited by Morris Fishbein, M.D., (\$5.00. *E. P. Dutton & Co. New York City*) covers every phase of the medical side of this war to date. Its authors are such men as Darling, Diehl, Grant, Griffith, Hawley, Kirk, Lull, McIntire, Moore, Parran, Rankin, Robinson, Rowntree, Ruse and Simmon.

**The Red Right Hand (An Inner Sanctum Mystery)** by Joel Townsley Rogers. (\$2.00. *Simon & Schuster, Inc., New York City*.) This story keeps you going and came to be recommended to you on these pages because of Dr. Henry N. Riddle, Jr., of St. John's Medical and New York S & P. It is a great yarn. The doctor happens to be the character who introduces you to the mystery.

**Essentials of Body Mechanics In Health and Disease**, by Drs. Joel E. Goldthwait, Lloyd T. Brown, Loring T. Swain, John G. Kuhns of Boston; and a chapter on the "Heart and Circulation as Related to Body Mechanics", by William J. Kerr of San Francisco, (\$5.00. 4th Ed. *J. B. Lippincott Co., Philadelphia*) is a book for all of us. As life expectancy increases posture means more and more to both us and our patients. In these days, it is important for us as physicians to see to it that our people have a good state of nutrition, with good body mechanics, and that our young people are physically fit to take military training; that all of us maintain a good posture so that our organs can function properly. But, above all, we must not, as leaders in the community, lose sight of nutrition, good posture, physical fitness, military training, and skill if our people shall maintain their present position as world leaders. So let's read every word of this book and put it in practice in our lives and explain it to our patients as a part of our treatment of them.

**Clinical Atlas of Blood Diseases**, by A. Piney, M.D., and Stanley Wyard, M.D., (\$5.00. 6th Ed., with 48 Illustrations, 45 in color. *The Blakiston Co., Philadelphia*) is a handy and popular atlas. If you have any occasion to look at blood smears, this little book will help you by recalling facts which you have forgotten as well as add something to your knowledge.

**My Second Life**, by Thomas Hall Shastid, M.D., (\$10.00. *George Wahr, Ann Arbor, Mich.*) contains over 1000 pages with numerous illustrations and tells in homely terms many interesting experiences of the author who has lived a long and a full life. It is therefore not only interesting reading but a good source book of Americana.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

August, 1945

No. 8

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

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## Experiences with the Photoroentgen Method in Chest Surveys: Analysis of 156,000 Examinations

ARCHIE FINE, M.D., and T. B. STEINHAUSEN, M.D.

THIS paper completes the statistical records of chest findings noted in the examination of 156,000\* prospective aviation cadets. Previous papers, 1 and 2, have dealt with groups of about 32,000 each.<sup>1, 2</sup>

All men were first examined by the photoroentgen method using 4 x 5 inch films. Suspicious lesions were checked by 14 x 17 inch films and if the findings were confirmed, the individual was admitted to the hospital for additional study.

The equipment consists of a 200 Ma X-ray unit with two stationary anode tubes mounted on a single tube stand. Tubes are alternated every 25 men (50 exposures). Tube life has been variable ranging from 3,000 to 48,000 exposures, the average about 25,000. The photoroentgen camera consists of a light proof box with a 14 x 17 inch fluoroscopic screen backed by a lead glass shield at the larger end. At the smaller end is a lens (F1.5) and behind is a film holder containing a 4 x 10 inch film.

When an exposure is made, an image appears on the fluoroscopic screen, this is reduced by the lens and a photographic impression is made on the film. The lead glass absorbs all the X-rays passing through the screen. In essence, the impression on the film is a photograph of the image on the fluorescent screen. The tube and film are shifted, a second exposure is made completing the stereoscopic shift.

The films are of excellent quality and we are convinced that for screening purposes, a stereoscopic pair of 4 x 5 films is as satisfactory

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as a single 14 x 17 film. Approximately 150-200 patients can be examined per hour and the radiologist can read as many with ease. It is our opinion that any competent radiologist will find little difficulty in attaining a high degree of accuracy after reading about a thousand films.

### RESULTS

Tables 1, 2, and 3 reveal the type of lesion encountered. Table 3 records the findings in 124,000 cadets. This smaller number is due to the fact that no record was made of these lesions in the first group.

### DISCUSSION

In analyzing these statistics, certain facts must be kept in mind. The men examined here are from 18-27 years of age. These men have been

Submitted November 10, 1944.

\*132,000 examined at the Nashville Army Air Center, Nashville, Tennessee; 24,000 examined at the Basic Training Center No. 10, Greensboro, N.C.

TABLE I (Non-Tuberculous Lesions)

|                                                            | Group I<br>0-32,000 |             | Group II<br>32,001-64,000 |             | Group III<br>64,001-100,000 |             | Group IV<br>100,001-132,000 |             | Group V<br>132,001-156,000 |             | Total<br>156,000 |             |
|------------------------------------------------------------|---------------------|-------------|---------------------------|-------------|-----------------------------|-------------|-----------------------------|-------------|----------------------------|-------------|------------------|-------------|
|                                                            | No.                 | Per<br>Cent | No.                       | Per<br>Cent | No.                         | Per<br>Cent | No.                         | Per<br>Cent | No.                        | Per<br>Cent | No.              | Per<br>Cent |
| Pneumonitis .....                                          | 44                  | 0.183       | 157                       | 0.491       | 130                         | 0.361       | 94                          | 0.293       | 147                        | 0.613       | 572              | 0.367       |
| Bronchiectasis proven by<br>bronchogram .....              | 3                   | 0.009       | 11                        | 0.039       | 14                          | 0.039       | 9                           | 0.028       | 4                          | 0.017       | 41               | 0.026       |
| Lung cyst or emphysematous<br>bleb .....                   | 1                   | 0.003       | 3                         | 0.009       |                             |             | 1                           | 0.003       | 0                          | 0           | 5                | 0.003       |
| Mediastinal adenopathy<br>(Probably non-tuberculous) ..... | 3                   | 0.009       | 5                         | 0.016       | 4                           | 0.011       | 1                           | 0.003       | 0                          | 0           | 13               | 0.008       |
| Lung abscess .....                                         |                     |             | 1                         | 0.003       | 1                           | 0.003       |                             |             | 1                          | 0.004       | 3                | 0.002       |
| Atelectasis .....                                          |                     |             | 1                         | 0.003       |                             |             |                             |             |                            |             | 1                | 0.0006      |
| Pneumothorax .....                                         |                     |             | 1                         | 0.003       |                             |             |                             |             | 1                          | 0.004       | 2                | 0.0013      |
| Hydropneumothorax .....                                    |                     |             |                           |             |                             |             | 1                           | 0.003       |                            |             | 1                | 0.006       |

TABLE II (Tuberculous Lesions)

|                                                                 |    |       |     |       |     |       |     |       |     |       |     |       |
|-----------------------------------------------------------------|----|-------|-----|-------|-----|-------|-----|-------|-----|-------|-----|-------|
| Miliary calcifications .....                                    | 11 | 0.034 | 11  | 0.034 | 13  | 0.036 | 5   | 0.016 | 6   | 0.025 | 46  | 0.030 |
| Inactive non-calcified lesions—                                 |    |       |     |       |     |       |     |       |     |       |     |       |
| Probably tuberculous .....                                      | 14 | 0.044 | 7   | 0.022 | 19  | 0.053 | 4   | 0.013 | 12  | 0.050 | 56  | 0.036 |
| Minimal tuberculosis .....                                      | 45 | 0.141 | 44  | 0.138 | 23  | 0.064 | 4   | 0.013 | 5   | 0.021 | 121 | 0.078 |
| Moderately advanced tuberculosis .....                          | 6  | 0.019 | 3   | 0.009 | 1   | 0.003 |     |       | 0   | 0     | 10  | 0.006 |
| Far advanced tuberculosis .....                                 | 1  | 0.003 |     |       | 1   | 0.003 | 1   | 0.003 | 1   | 0.004 | 4   | 0.003 |
| Non-tuberculosis lesions .....                                  | 51 | 0.159 | 178 | 0.561 | 149 | 0.41  | 103 | 0.322 | 153 | 0.638 | 638 | 0.407 |
| Tuberculosis lesions (excluding<br>miliary calcification) ..... | 66 | 0.207 | 54  | 0.169 | 44  | 0.12  | 13  | 0.041 | 18  | 0.075 | 191 | 0.123 |

TABLE III

Miscellaneous Lesions not Included in Table I  
Total 124,000 Examinations

|                                                          | No.   | Per<br>Cent |
|----------------------------------------------------------|-------|-------------|
| A. Bifid ribs .....                                      | 681   | 0.549       |
| Cervical ribs .....                                      | 69    | 0.056       |
| Rudimentary ribs .....                                   | 79    | 0.084       |
| Synostosis of ribs .....                                 | 254   | 0.205       |
| Rib tumor (Osteochondroma) .....                         | 2     | 0.002       |
| Azygos lobe .....                                        | 339   | 0.273       |
| B. Parenchymal calcifications .....                      | 2,387 | 1.925       |
| Hilar calcifications .....                               | 4,021 | 3.243       |
| Combined hilar and paren-<br>chymal calcifications ..... | 1,273 | 1.207       |

in the army for varying lengths of time. Some only a few months, others more than two years. The first group of 32,000 did not have a high percentage of induction films roughly about 60-70 per cent. The number having been X-rayed before has shown a steady increase so that practically all the last two groups had had a chest roentgenogram at one time or other in their army careers.

This is well exemplified by the successive decrease in the incidence of tuberculosis lesions, viz.: 0.207, 0.169, 0.122, 0.041, 0.075 per cent. Included in this figure are those instances of fibrotic lesions unchanged over a period of months with positive reactions to tuberculin. This marked decrease in incidence of pulmonary tuberculosis concomitant with the fact that practically every cadet had had at least one X-ray of his chest during his army career points the way to detecting and eliminating tuberculosis as a cause of morbidity and mortality.

These were individuals who had some type of infiltration usually in one or the other lobes. Favorite sites were the cardiophrenic or costo-

phrenic angles. Most of the men when admitted to the hospital had mild or no clinical symptoms and the roentgen findings disappeared in one to three weeks. Those lesions present in the upper lobes were with difficulty distinguished from pulmonary tuberculosis. The rapid change in roentgen findings made the differentiation.

#### BRONCHIECTASIS

When the roentgen findings persisted after three or four weeks with little or no change, a bronchogram was performed. Forty-one cases in all were discovered. Many of these men denied all symptoms but persistent questioning and follow-up questionnaires in civilian life disclosed that a large number had a chronic cough and expectoration.

This follow-up study on these men has disclosed some interesting facts, which will be the subject of a more comprehensive paper. Suffice to say that one individual has died presumably from brain abscess and empyema. Three have had check-up X-rays by civilian physicians and the report is that their chests are clear. None as yet has had bronchograms.

As to the etiology, six men dated onset of their disease to a bout of pneumonia which persisted over two or three months. In three instances we were able to obtain films on induction prior to the pneumonia and they showed normal lung findings. While the role of atypical pneumonia of unknown etiology in the production of bronchiectasis has as yet to be proved, it would appear from our preliminary findings that it may play a part in its causation.

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# Factors in Reducing the Recurrence Rate in Therapy of Varicose Veins

R. KENT FINLEY, M.D., and JAMES MILO SHAFFER, M.D.

THE patient suffering from severe varicosities involving the lesser or greater saphenous system, or both, presents a problem and a challenge that has all too often been minimized. The high percentage of recurrences following simple injection therapy or inadequate surgery is formidable. Every aid in therapy, no matter how small, must be utilized to reduce that recurrence rate. Thorough eradication of varicose veins can never be done in a careless manner. Far too many patients are injected week after week when a careful examination on the first visit would have shown beyond a doubt that injection therapy never was indicated and should never have been started.

The majority of patients seeking relief from varicosities present themselves with obviously incompetent sapheno-femoral valves, and a large percentage in addition have incompetent communicating branches and what Pratt<sup>1</sup> so aptly calls "blow-outs". Symptoms of easy fatigue, aching pain in the legs, inability to walk or to be on the feet for a long period of time are common.

## EXAMINATION

Careful examination of all patients is imperative before determining the therapy indicated in each case. A history of allergy, or of previous injections, is extremely important because of the possibility of sensitivity to the sclerosing solution. The existence of an old thrombo-phlebitis must be investigated and well tested for and, if indicated, a venogram done. (Figure 1.) The presence of organic vascular disease, such as arteriosclerosis, should be checked; although diminished vascular supply to an extremity is no longer considered to be a positive contraindication to eradication of large pools of poorly flowing blood which certainly places an added burden on already overworked arteries. Perthe's test and its modifications, the double Trendelenburg test, the percussion test as demonstrated so well by McCallig and Heyerdale<sup>2</sup> and tests for the presence of "blow-outs" or incompetent communicating veins, should be carefully done.

Search for these incompetent branches between the deep and superficial venous system, followed by their surgical ligation, must be carried out thoroughly to minimize the number of recurrences. For several years we have established the

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practice of marking these points for secondary ligation with 20 per cent silver nitrate solution. This can be done in the office, with the full cooperation of the patient, several days before surgery. A black mark on the skin which resists wear and application of antiseptic solutions appears within a few hours after the silver is applied. Care should be taken to use fresh silver and not to rub the skin vigorously. The marks so applied remain during the operation and easily outline the points for incision.

## LIGATION

A great deal has been written about the surgical treatment of varicosities. If simple ligation of the saphenous vein is done, varicosities will not be completely eradicated for two reasons. First, the tributaries emptying into the bulb will enlarge, reestablishing circulation in the long saphenous vein. Second, even if adequate surgery is performed in the groin, varicosities will remain or recur in the lower leg up to the point of the communicating branch to the deep circulation because of back pressure through the incompetent valves in that communicating vein. Thus, the most important points in the surgical treatment are high ligation of the saphenous vein at the sapheno-femoral junction to prevent any blind pocket for possible future emboli, careful search for and ligation of all tributaries, and finally, ligation of all "blow-outs" at the points marked with silver nitrate solution. We also feel it is advantageous to resect several inches of the saphenous vein.

The question of whether to do a retrograde



Figure 1. Venogram showing a completely obstructed femoral vein approximately in the region of Hunter's canal; the result of an old thrombophlebitis. The patient has severe varicosities about the knee and lower leg which must be treated conservatively without ligation or injection.

injection of sclerosing solutions has been much debated. At the present time, the Army Medical Corps looks with disfavor upon this procedure. However, if carefully used, with attention paid to several details in the selection of the solution, the amount inserted and the method of insertion, we firmly believe that retrograde sclerosis greatly improves the end results and prevents recurrences. Pratt<sup>3</sup> has shown by histological sections of veins, that the sclerotic effect from any injecting solution is localized and to sclerose a large vein the solution must be uniformly and segmentally distributed. Injections of a few cubic centimeters of solution through a needle in the distal end of the cut saphenous does not thoroughly distribute it nor produce the maximum amount of sclerosis needed to completely occlude the vein.

The use of a fine ureteral catheter, no larger than size five, and its rapid but gentle insertion will prevent any injury to the vein. Often a slight twist of the catheter will carry it past a valve down into the lower leg, but undue force should never be used. Slow withdrawal of the catheter as the solution is being inserted insures an even distribution of sclerosing material along the course of the vein and prevents pooling at any one spot. Thorough irrigation of the wound with saline when the catheter is withdrawn will prevent local wound irritation.

A procedure which we have found very helpful in obtaining a better distribution of the sclerotic is to elevate the leg to drain the saphenous vein prior to insertion of the catheter. Immediately after insertion of the catheter and for several minutes after the solution has been injected, the leg is placed in a dependent position. This may be simply attained by placing the patient in high Fowler's position (Figure II).

Another step in helping to distribute the sclerosing solution well and to prevent emboli is to have the patient walk at the close of the operation and frequently thereafter. Harkins<sup>4</sup> feels that no patient should remain quiet longer than seven consecutive hours during the first two weeks after ligation. The leg should be completely wrapped using four inch elastic bandages, with care taken to place pressure pads at any point along the leg showing even the slightest redness or reaction to the sclerotic. These bandages should be checked frequently, the leg inspected and pressure pads reapplied at any reddened or tender area.

#### ANESTHESIA

By the use of local anesthesia, early walking and prevention of local reaction to the solution, hospitalization need only take a maximum of twenty-four hours. We feel it advisable to wait at least forty-eight hours before operation on the other leg, where bilateral varicosities are present. Thorough surgery, with care taken in dissection and in carrying out all the details necessary to ensure a completely successful result, can not be done rapidly. Neither can the patient get up and walk about as readily if both legs are operated upon at the same time.

Another factor playing an important part in varicose vein surgery, but often neglected, is the possibility of wound infection. The incision made over the sapheno-femoral junction is, of necessity, high on the inner aspect of the thigh where sweat glands are abundant and skin sterilization often difficult to achieve. Operation should be deferred on patients during or close to the menses. Thorough skin cleansing with soap and



water, and when indicated a cleansing douche the morning of operation, are desirable.

Following surgery, dressings over the wound are difficult to maintain in place with ordinary adhesive because of perspiration, and contamination of the wound is a frequent complication. We have found that the use of elastic adhesive bandage eliminates most of these objections. Strips of elastoplast are cut about twelve inches long and applied in layers over the dressings. This type of dressing molds itself well to the folds of the lower abdomen and thigh, completely covering and thoroughly protecting the wound. It will not slip and need not be disturbed until the patient presents himself to the office six or seven days after surgery for the first dressing.

Infection in the small incisions over the competent communicating branches is not uncommon because of the superficial position of the veins and the thin, easily traumatized skin over them. Gentleness in handling the skin and the use of



Figure II. The table is inclined at about a forty-five degree angle as a fine ureteral catheter is slowly withdrawn as sclerosing solution is injected. A large constant communicating vein is shown dissected free at the mid-portion of the thigh.

extremely fine sutures, such as number 80 to 120 white cotton, has cut infection at these points to a minimum.

#### CONCLUSION

The problem of successful treatment of varicose veins is increasingly important because of the common existence of this disabling condition and the many recurrences following inadequate therapy. Thorough eradication of varicosities with the smallest possible recurrence rate depends upon strict attention to the small details, patient, thorough surgery, and a complete basic knowledge of the physiology and anatomy of the superficial venous system. Injection therapy is indicated in selected cases, but should not be done indiscriminately whenever a dilated vein is seen.

When surgery is indicated, high ligation of the saphenous vein with ligation of all tributaries at the sapheno-femoral junction is imperative. Retrograde segmental sclerosis by the use of a

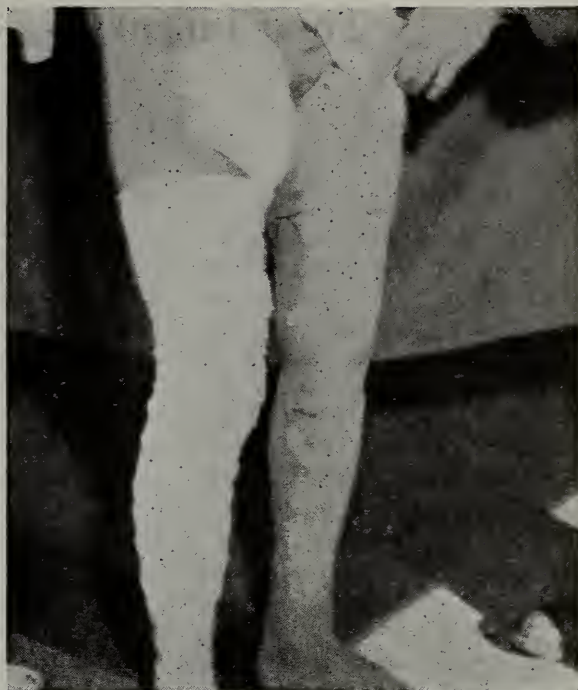


Figure III. Elastic adhesive plaster (Elastoplast) is used to cover the dressings in the right groin providing a sealed sterile dressing which molds itself to the skin, thus preventing contamination and infection. The remainder of the leg is wrapped with ordinary elastic bandage with pressure pads over large veins. "Blowouts" marked with silver nitrate are evident on the left leg.

fine ureteral catheter, gently inserted, is an important adjunct, combined with secondary ligation of all incompetent communicating branches between the deep and superficial venous system.

In addition, we have used three procedures, which are not original in principle, but which have proven to be of value in obtaining more thorough and satisfactory results. These, are, first, careful marking of incompetent communicating branches with 20 per cent silver nitrate which may be applied several days before surgery and provide an absolute guide for placing incisions. Second, draining the vein prior to injection of the sclerosing solution followed by placing the leg in a dependent position to allow a more even distribution of sclerosing material along the course of the varicosities. Third, the use of elastic adhesive in sealing off the dressings in the potentially infected groin, providing an outer dressing which holds firmly, molds to the skin, and seals the wound completely.

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# The Clinical Use of Anti-Coagulants

HELEN IGLAUER GLUECK, M.D.\*

RECENT years have shown an increasing interest in the use of anti-coagulants. The clinician is becoming aware of the serious nature of thrombosis and emboli. Whereas therapy formerly consisted of "watchful waiting", certain new methods have of late come into prominence. Among these are the anti-coagulants. There is already a sizable literature on the use of anti-coagulants. However, accumulated case reports, even of a modest series, may be of value especially when considered in conjunction with the larger series reported by various authors. Since the precise actions of the two chief anti-coagulants, heparin and dicumarol, are still not entirely understood caution must be employed in the interpretation of results. The present paper will describe a series of patients treated either with dicumarol or heparin alone, or heparin and dicumarol combined.

Schofeld<sup>1</sup> in Canada and Roderick<sup>2</sup> in this country first described a hemorrhagic disease in cattle acquired by eating spoiled sweet clover. It remained, however, for Link<sup>3</sup> and his associates, in a series of brilliant papers, to isolate the active principle, dicumarol, responsible for the anti-coagulant action of spoiled sweet clover. From Link's discovery, it was a natural step to the use of dicumarol in clinical medicine.

The earliest clinical papers on dicumarol were published by Meyer, Bingham and Pohle;<sup>4</sup> Butt, Allen and Bohlman;<sup>5</sup> Prandoni and Wright.<sup>6</sup> Since then, there have been a large series of papers on the clinical use of dicumarol either alone or in conjunction with heparin.<sup>7-19</sup>

## METHODS AND MATERIALS

A total of 44 patients were treated with anti-coagulant therapy. All of these patients were hospitalized, and under the direct supervision of the author. Since most of the cases were referred by surgeons, there was always the closest cooperation between the surgeon and the internist. Of the 44 patients, 30 received dicumarol alone, 11 heparin and dicumarol combined and 3 heparin alone. The cases in Table I, are classified into four large groups. As seen in Table I—1. Phlebothrombosis in which infarct preceded the clinical signs of phlebitis; 2. Post-operative thrombophlebitis either with or without pulmonary infarction; 3. Post-partum thrombophlebitis; 4. Thrombophlebitis of unknown etiology. Careful distinction should be made between throm-

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bophlebitis and phlebothrombosis. In thrombophlebitis, there is always involvement of the vein with infection and reactive inflammation, so that the thrombus is intimately connected with the intimal lining of the vein. Phlebothrombosis is a term applied to that condition in which there is no injury to the intima of the vein, the thrombus simply lying at the lumen of the vein. Since the thrombus is not attached to the wall of the vein, it is more apt to become detached and form an embolus. This distinction should be made in considering any studies of thrombophlebitis.

Table II represents a group of miscellaneous conditions which will be discussed later. All the cases in Table I were true thrombophlebitis of the deep veins of the legs. No cases of simple saphenous thrombophlebitis are included. The patients exhibited the usual signs of thrombophlebitis locally with step-ladder elevation of temperature and pulse. Homan's sign was positive in 80 per cent of the entire series.

## THE METHOD OF THERAPY

The method of therapy will be briefly discussed. As we gained experience with the drug, we became more inclined as did Evans<sup>8</sup> and others to use heparin and dicumarol\* combined, particularly in severe cases where embolism threatened or had already occurred, or where arterial embolism had recently taken place. The combined use of heparin and dicumarol shortens the latent period of dicumarol which may not begin to demonstrate its anti-coagulant effect for 24 to 72 hours after its administration. Thus, valuable time may be lost when it is most needed. Heparin on the other hand, will show an immediate anti-coagulant effect, which persists only for 2 to 4 hours after the drug is discontinued. Therefore, if any immediate anti-coagulant effect is desired and the more sustained effect of dicumarol is in-

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\*The dicumarol in these studies was furnished by the W. S. Merrell and Company.



icated, the drugs may be given simultaneously. The effect of dicumarol may persist 4 to 12 days after the last dosage of the drug.

The most economical method at present of administering heparin is intravenously by the continuous drip. This method was used in all but two cases to be described later. Two hundred mgs. of heparin were added to a liter of saline and drip started at 25 drops a minute. Clotting times were determined usually by the capillary method, at four-hour intervals and an attempt was made to maintain the clotting time about 10 minutes with this method. Although the clotting time by the capillary method is known to be less accurate than the Lee and White method, we felt that its simplicity was of great importance, and clotting time could be determined more often when venous punctures were eliminated.

The capillary tubes used for the determinations were all of the same standard size. The blood was allowed to flow freely from the puncture wound. The tube was left warmed in the palm of the hand and tilted in the hand. When the column of blood ceased to gravitate in the capillary tube, the tube was then broken until the "thread" of the end point was reached. Occasionally when after several days of heparin administration, we were able to determine quite accurately the amount of heparin needed for that patient, we would substitute two daily determinations of the clotting time by the Lee and White method, for the four-hourly capillary method. The rate of the flow of heparin solution was regulated by the clotting time. There were wide variations in the amount of heparin needed, the average cases requiring between 300 to 600 mgs. daily.

If dicumarol was administered, either with or without heparin, the usual initial dose was 300 mgs. on the first day, following by 200 mgs. on the second day, subsequent dosage varying from none to 200 mgs., being determined by the daily prothrombin time. The prothrombin time was determined by the method of Quick, always, running a control plasma. The results were reported not only in "prothrombin time", but in percentage of normal, as calculated from Quick's curve, with modification for the particular batch of thromboplastin being used.<sup>20</sup> The thromboplastin used (Difco) was prepared fresh each day. We soon discovered that it was best to have the same technician run the determinations each day, since the method is not without error unless carefully done. We attempted to maintain the prothrombin concentration between 20 to 50 per cent of normal, lower concentrations appearing no more effective than these and somewhat dangerous.

The daily dose of dicumarol was never given until the morning's report of the prothrombin time had been obtained. If the prothrombin time

was above 50 per cent of normal, 100 to 200 mgs. of the drug was administered; if below 20 per cent, no drug was given. If the level was rising from 30 per cent of normal to 40 per cent, for instance, perhaps 100 mgs. might be given. The matter of dosage is far from arbitrary and was determined only when following the daily levels of prothrombin. It soon became evident which patients were sensitive to, and which resistant to the drug.

It should be emphasized that there are tremendous variations in the amount of dicumarol needed to depress the prothrombin concentration of the blood. The term "average dose" is really a misnomer. Thus, in two cases of subacute bacterial endocarditis, 300 mgs. produced tremendous rises in the prothrombin time to 40 seconds or above, (less than 5 per cent concentration) while in a second patient with multiple sclerosis, given over 3,200 mgs. of the drug during a two weeks' period, the lowest concentration of prothrombin fell to only 70 per cent of normal. These tremendous variations in the dosage of the drug is one of its chief disadvantages.

#### DICUMAROL AND HEPARIN

When dicumarol and heparin were administered together, the clotting time as previously described was used to indicate the effect of the heparin, and the effect of dicumarol was determined by daily prothrombin determinations. Since heparin does not effect the prothrombin time appreciably, after the prothrombin time had fallen to 20 to 50 per cent of normal concentrations, the heparin was then discontinued and the dicumarol continued for as long as desired. It usually required 1 to 4 days of heparinization, before the drug could be discontinued.

As emphasized by all who employ dicumarol, the only safe way to follow its mechanism is by daily prothrombin determinations. Whereas the clotting time usually shows some retardation with dicumarol, the prothrombin concentrations may reach dangerous levels with only moderate alterations in the clotting time. Therefore when administering dicumarol, we occasionally determined the clotting time as a matter of interest, while daily prothrombin times were considered a necessity. The duration of the treatment was determined by the progress of the patient—the average length of treatment with the drug being 17 days. Where indicated because of the underlying pathologic condition often associated with the phlebitis, chemotherapy was used along with the anti-coagulants.

#### COMPLICATIONS

The most serious complication of dicumarol therapy is hemorrhage. In our total series of cases, hemorrhage occurred six times, a percentage of 13.6. If two cases of subacute bacterial

TABLE I  
Thrombophlebitis and Phlebothrombosis

|                                                                               | Number | Dicu-<br>marol<br>Alone | Dicu-<br>marol<br>Heparin<br>Com-<br>bined | Heparin<br>Alone                                                   | Average<br>Number<br>Days<br>Treat-<br>ment | Recurrence<br>or Exten-<br>sion of<br>Phlebitis | Hemorrhage<br>or Purpura                  | New or<br>Recurrent<br>Infarct<br>After<br>Therapy<br>Com-<br>menced | Result                           | Comments                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------|--------|-------------------------|--------------------------------------------|--------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Phlebothrombosis in which infarct preceded the clinical signs of phlebitis | 9      | 8                       | 1                                          | 0                                                                  | 15                                          | 0                                               | 0                                         | 0                                                                    | Complete recovery in all 9 cases | <p>Appendectomy 2</p> <p>Hysterectomy 2</p> <p>Laminectomy 1</p> <p>Fracture 1</p> <p>Bilateral hernioplasty 1</p> <p>Etiology unknown 1</p> <p>Following trauma 1</p> <p>2 infarcts before ligation of femoral vein—one following ligation. No new infarcts with anti-coagulant therapy</p> |
| 2. Postoperative thrombophlebitis                                             | 14     | 9                       | 4                                          | 1<br>Used be-<br>cause of<br>previous<br>history of<br>metorrhagia | 16                                          | 2-1 mild<br>1 septic<br>thrombo-<br>phlebitis   | 1                                         | 0                                                                    | 1 Death*                         | <p>Pilonidal cyst 1</p> <p>Hysterectomy 6</p> <p>Laminectomy 2</p> <p>Fracture 2</p> <p>Dilatation and curettage 1</p> <p>Resection of sigmoid—large infarct 1</p> <p>Cholecystotomy and liver abscess 1*</p>                                                                                |
| 3. Postpartum thrombophlebitis                                                | 4      | 1                       | 3                                          | 0                                                                  | 21                                          | 1 mild                                          | 0                                         | 0                                                                    | Complete recovery in all 4 cases | 2 patients each had 2 infarcts before onset of therapy—one also had a probable mesenteric thrombosis                                                                                                                                                                                         |
| 4. Thrombophlebitis, etiology unknown                                         | 6      | 5                       | 1                                          | 0                                                                  | 16                                          | 0                                               | 1 case of purpura<br>1 case of hemorrhage | 0                                                                    | Complete recovery in all 6 cases | 1 case had one large infarct preceding therapy—marked bilateral phlebitis and edema to the umbilicus. Sympathetic nerve block done before admission to Cincinnati General Hospital                                                                                                           |
|                                                                               | 33     | 23                      | 9                                          | 1                                                                  | 17                                          | 9%                                              | 9%                                        | none                                                                 | 3% mortality                     | *Death—no autopsy. Cholecystotomy followed with 2 operations for liver abscess—probable septic thrombophlebitis—and femoral arterial embolus.                                                                                                                                                |



endocarditis are excluded and one in which purpura was the only manifestation of hemorrhage, the percentage is 7 per cent. This complication appeared in spite of careful daily controlled prothrombin time determination. This complication will be discussed further in the case histories to follow. Cases 1 to 4 will be used to illustrate the complication of hemorrhage.

#### CASE HISTORIES

##### Case 1

R. K. was referred to the hospital with a deep thrombophlebitis of his left leg. He was started on dicumarol therapy and on the fifth day of therapy, he began to have an almost uncontrollable nose bleed when his prothrombin concentration fell to 30 per cent of normal. He required four transfusions of fresh blood to control the hemorrhage. Further questioning developed the fact that this patient had been subject to severe nose bleeds in the past and had had hypertension. His previous history should have precluded the use of dicumarol.

##### Case 2

E. P.—This patient had contracted a marked thrombophlebitis of the left leg, following infectious mononucleosis from which she had apparently completely recovered. A questionable pulmonary infarct had occurred in another hospital at the onset of her phlebitis. During a two weeks' period, she received 1,450 mgs. of dicumarol with marked improvement. On the fifteenth day of therapy, her prothrombin time was seventeen seconds, 60 per cent of normal. She was given an additional 200 mgs. of the drug. Following this on the seventeenth day, the prothrombin time suddenly rose to sixty-three seconds, (less than 5 per cent of normal), and remained elevated for six days. She developed an acute purpuric eruption of her skin, but no other complication ensued and she made an uneventful recovery without the use of transfusions.

##### Case 3

B. E., a 32 year old white female, was operated on for endometriosis and had had a curettage and oophorectomy. On the sixth postoperative day, she developed a femoral thrombophlebitis of the right leg. She was given dicumarol with good therapeutic results, the phlebitis disappearing on the fourth day after the onset of therapy. On the fifth day of therapy with the prothrombin time at twenty-two seconds, (40 per cent of normal), she began having vaginal bleeding. Dicumarol was discontinued and within three days, the prothrombin time fell to normal levels. However, she continued to have excessive bleeding and required three transfusions. Bleeding was only controlled by a subsequent curettage at which time a marked endometrial hyperplasia was noted. With curettage, the bleeding ceased, but during subsequent menses she bled profusely. Finally, hemorrhage could only be controlled by a pan-hysterectomy.

It should be noted at this juncture that in three of the total series of our patients, menstruation occurred during therapy, and no abnormal hemorrhage resulted. It should be added that these cases have all had previously normal menstrual periods without menorrhagia.<sup>21</sup>

##### Case 4

The present illness had commenced seven years before admission with thrombophlebitis of the right saphenous vein. A second episode of phlebitis five years later, involved both femoral veins. After twelve months of conservative therapy, bilateral saphenous ligation was performed. Shortly after this, she developed a pulmonary infarct. During the last year, she had developed painful, transitory, migratory thrombophlebitis involving all four extremities. Because of the persistence of symptoms, she was given a twenty-one day course of anti-coagulant therapy, using 2,150 mgs. of dicumarol. She noted disappearance of her pain and subsequently, felt much improved. After a three weeks' rest period, it was decided to attempt another period of therapy because of the apparent improvement. The dose of dicumarol was controlled with prothrombin determinations on alternate days.

In the fifth week of her second course of therapy she suddenly developed a massive and frank hematuria. The Rumpel-Deede sign was negative, but large echymoses were noted on her thighs. The prothrombin time was 19.5 seconds with a control time of 14 seconds (48 per cent of normal), at the onset of the hematuria. Gross hematuria persisted for five days, in spite of four transfusions of 500 cc. of whole fresh blood and three intravenous injections of 64 mgs. of \*medanione (synthetic vitamin K 1). Although the prothrombin time rose to 80 per cent of normal following the first transfusion, the clotting time never exceeded 5 minutes (Lee and White method).

It should be emphasized in this patient that bleeding persisted in spite of a prothrombin time which was not excessively low. Cahan<sup>22</sup> has reported a similar case. Once the gross hematuria had ceased, she made an uneventful recovery. The toxic effect of the drug in this patient seemed to bear no relation, however, to the prothrombin concentration. The only possible contributory factor was four plus cephalin flocculation test on the second admission following the hemorrhage which returned to normal on the fifth day. The cephalin flocculation test on a previous admission had been normal. Large doses of medanione were apparently unsuccessful in controlling the hemorrhage.<sup>23-26</sup>

Before continuing the discussion of the use of anti-coagulants in the miscellaneous series of cases, it would be well to describe in some detail, a case which showed some of the difficulties of anti-coagulant therapy and the successful conclusion of this difficult problem.

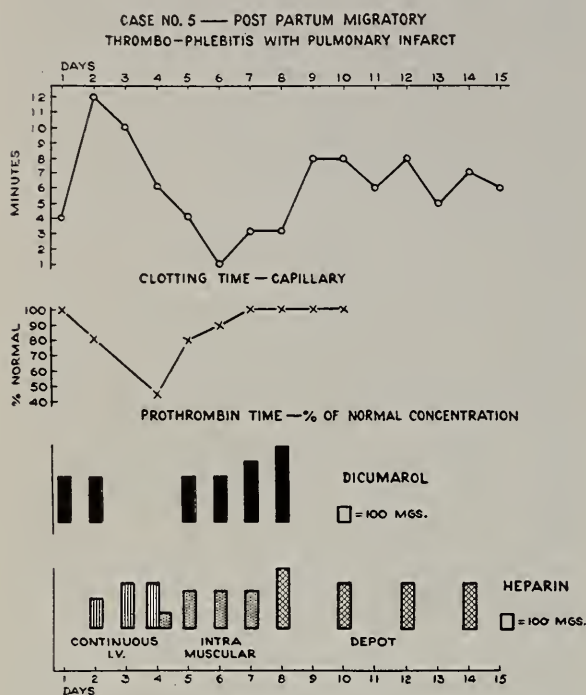
##### Case 5

C. B., a white female, aged 32, delivered a normal infant with a normal labor on 3-11-44 in another hospital. On the third and fourth postpartum day, she complained of vague pains in her right foot. On the ninth day postpartum day, she developed transient swelling and redness of her right foot and calf and sudden pain in the calf on standing. These symptoms disappeared 12 hours after their onset. On the thirteenth postpartum day, she suddenly suffered severe pain at the left costal margin aggravated by cough or deep inspiration. The symptoms persisted and on the fifteenth day a friction rub was heard at the base. This episode was recog-

\*The medanione in this series was furnished through the courtesy of the William S. Merrell and Company.



nized as a pulmonary embolism and infarction. After a few days, the symptoms disappeared. On the twenty-first postpartum day, she developed excruciating pain in her left calf posteriorly and slight edema of the left foot. On the thirty-fifth postpartum day, she developed pain in her right shoulder and pain in her right chest ag-



gravated by deep breathing and cough. Moreover, she exhibited definite tenderness along the course of the right external jugular vein.

A review of the case at this time, suggested a history of a bilateral femoral thrombophlebitis, two episodes of pulmonary embolism and a probable migratory thrombophlebitis now involving the brachial and jugular vein as well as legs. Subsequently, anti-coagulant therapy was commenced with heparin intravenously and dicumarol orally. Heparin was commenced intravenously at the same time the dicumarol was given orally, 300 mgs. the first day, and 200 mgs. the second day. On the first day of therapy, she was given 200 mgs. of heparin by continuous drip, 300 on the second, 300 on the third supplemented by 50 mgs. intramuscularly. The clotting time checked at four-hour intervals, capillary method, showed only a moderate rise. Apparently the patient was somewhat refractory to heparin, requiring large doses. Because of extremely poor veins, great difficulty was experienced in continuing the drip. Consequently, it was decided to give the heparin intramuscularly along with dicumarol orally as suggested by Rhodes.<sup>27</sup> The prothrombin showed moderate fall on the fourth day of therapy, but in spite of 300 mgs. of heparin intramuscularly during a twenty-four hour period, the clotting time showed marked acceleration. This tendency continued for the next three days until the clotting time became so rapid on the sixth day of therapy, it could scarcely be measured in the capillary tube.

Moreover, after an initial fall in prothrombin concentration, the prothrombin concentration rapidly rose to normal concentrations in spite of a total dose of 2,000 mgs. of dicumarol in eight days. This patient appeared refractory to dicumarol and perhaps therefore did not show

the synergistic action of heparin intramuscularly and dicumarol orally as reported by Rhodes.<sup>27</sup> At this juncture, we were able to obtain a supply of heparin in Pitkin's menstrum, through the courtesy of Dr. Leo Loewy. Four hundred mgs. were administered subcutaneously on the eighth day of therapy and 300 mgs. were administered as indicated subsequently on alternate days. The clotting time gradually rose to satisfactory levels and the patient made an uneventful recovery with no further extension of her phlebitis and no new infarcts.

This case demonstrates several interesting clinical problems. The demands for relatively large amounts of heparin intravenously in certain cases, the presence of resistance to dicumarol with poor response to the drug, the relative inadequacy of heparin intramuscularly in this case, although Rhodes<sup>27</sup> has reported synergistic action between heparin intramuscularly and dicumarol orally, and finally a good response to the depot method of administering heparin. Moreover, the patient seemed to demonstrate even with capillary methods of prothrombin determinations (done by necessity and not by choice) which are known to be inadequate, a marked tendency to accelerated coagulation and clot retraction. This interesting angle of thrombophlebitis is receiving continued attention and is being developed into a new clinical concept. Wright,<sup>28</sup> De Takats,<sup>29</sup> Bramble,<sup>10</sup> Shapiro,<sup>30</sup> Waugh,<sup>31</sup> Hirshboeck,<sup>32</sup> and others have all made recent attempts to determine this aspect by laboratory methods. It is by such studies that we may extend our knowledge of thrombosis and emboli. It seems that in this patient a serious and progressive condition was successfully controlled by a new and most promising method of anti-coagulant therapy.

#### THE SECOND SERIES

The second series of cases represent certain miscellaneous conditions in which anti-coagulant therapy was used. No conclusions can be reached from such a small series, but certain cases will be briefly described. Two cases of subacute bacterial endocarditis terminated fatally, following the use of dicumarol, probably from cerebral hemorrhage. The results of dicumarol therapy, at least as reported without using penicillin are uniformly disappointing in the hands of all observers of this disease. These patients appeared extremely sensitive to the drug, in each case, only 300 mgs., producing excessive prolonged depression of prothrombin concentration. Both patients had marked febrile reactions, and as Richards<sup>33</sup> had demonstrated experimentally the usual dose of dicumarol, in experimental animals, subject to high temperatures, will produce excessive fall in prothrombin concentrations. It appeared that dicumarol alone has no place in the therapy of subacute bacterial endocarditis.

The case of migratory thrombophlebitis has



**TABLE II**  
**Miscellaneous Group of Conditions Treated With Anti-Coagulant Therapy**

|                                    | Number | Dicu-<br>marol<br>Alone | Dicu-<br>marol<br>Heparin<br>Com-<br>bined | Heparin<br>Alone | Days<br>Therapy                | Hemorrhage | Result                   | Comments                                                                                                                                     |
|------------------------------------|--------|-------------------------|--------------------------------------------|------------------|--------------------------------|------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Subacute bacterial endocarditis | 1      | +                       | 0                                          | 0                | 7                              | ++         | Death                    | Hemolytic streptococci endocarditis—1 embolus with good levels of prothrombin depression—death probably cerebral hemorrhage—sulfa given      |
|                                    | 2      | +                       | 0                                          | 0                | 20                             | Purpura    | Death                    | No autopsy—strep-viridans—sulfa Rx                                                                                                           |
|                                    | 3      | 0                       | 0                                          | +                | 21                             | 0          | Recovery                 | Rheumatic heart disease—strep-viridans—penicillin                                                                                            |
|                                    | 4      | 0                       | 0                                          | +                | 11                             | 0          | Recovery                 | Pneumococci endocarditis—tricuspid insufficiency—penicillin—sulfadiazine.                                                                    |
|                                    | 4      | 2                       | 0                                          | 2                | 15 average                     | 50%        | 50% mortality            |                                                                                                                                              |
| 2. Multiple sclerosis              | 1      | +                       | 0                                          | 0                | 22                             | 0          | No improvement           | Resistant to drug                                                                                                                            |
|                                    | 2      | +                       | 0                                          | 0                | 53                             | 0          | No improvement           |                                                                                                                                              |
|                                    | 2      | 100%                    | 0                                          | 0                | 37.5 average                   | 0          | No improvement           |                                                                                                                                              |
| 3. Lateral sinus thrombosis        | 1      |                         | +                                          | 0                | 11                             | 0          | Recovery                 | Followed mastoid sulfadiazine — hemo-strep. isolated from sinus                                                                              |
| 4. Migratory thrombophlebitis      | 1      | +                       | 0                                          | 0                | 21—1st course<br>22—2nd course | ++         | Questionable improvement | Massive renal hemorrhage                                                                                                                     |
| 5. Arterial occlusion              | 1      | 0                       | +                                          | 0                | 8—1st course<br>21—2nd course  | 0          | Amputation 1 leg         | Arterial occlusion both legs—myocardial infarct—1st occlusion treated dicumarol alone—amputation—2nd occlusion—combined therapy and recovery |
|                                    | 2      | +                       | 0                                          | 0                | 11                             | 0          | Recovery                 | Arterial occlusion 1 leg—thrombophlebitis other leg—diabetes—gangrene 1 toe                                                                  |
|                                    | 3      | +                       | 0                                          | 0                | 10                             | 0          | Recovery                 | Rheumatic heart disease—auricular fibrillation                                                                                               |
| Totals                             | 3      | 66%                     | 33%                                        | 0                | 12 average                     | 0          |                          |                                                                                                                                              |
| Grand Total                        | 11     | 7                       | 2                                          | 2                |                                | 27%        |                          |                                                                                                                                              |

already been described. Although clinically she appeared somewhat improved, hemorrhage, a serious complication in her case, excluded any possible advantage. Wassermann<sup>11</sup> reports no improvements in 10 cases of occlusive peripheral vascular disease treated with dicumarol over a three months' period. Wright and Prandoni<sup>12</sup> have used it in four cases of migratory thrombophlebitis. They were unable to reach any definite conclusions in their series.

Two cases of multiple sclerosis were given extensive and prolonged therapy with dicumarol, following certain work of Putnam<sup>34</sup> which suggested that multiple sclerosis might result from numerous small thrombi of the vessels of the spinal cord. One patient who was markedly resistant to the drug received 1,500 mgs. during the first week of therapy with only a 3-second elevation of the prothrombin time. During a later course, he received 2,000 mgs. of the drug in four days. His prothrombin concentration still remained at 80 per cent of normal. The second patient was treated for 53 consecutive days with the usual response to the drug. As judged by cephalin flocculation and galactose tolerance tests, careful hematological study and renal function tests, the dicumarol appeared harmless. In neither case was there any clinical improvement noticed. Reese<sup>35</sup> has recently reported a large series of patients treated with dicumarol with no objective improvement.

One patient with lateral sinus thrombosis, following otitis media and mastoiditis, responded well to chemotherapy plus combined heparin and dicumarol.

The final group consists of three cases of arterial embolism, treated with anti-coagulant therapy with fairly good results.

#### Case 6

A. S.—A 21 year old white female was suffering from rheumatic heart disease, mitral stenosis and auricular fibrillation. Five weeks before her hospital admission, she had had a cerebral thrombosis and left hemiplegia with spontaneous recovery. On the day of admission, she suddenly developed excruciating pain in her left calf, thigh and foot. The leg appeared cold, clammy and edematous. The popliteal, anterior tibial and posterior tibial pulsations were imperceptible. Pain was excruciating. Therapy was commenced with dicumarol with fortunately good results. The prothrombin time fell rapidly in 24 hours. Supportive therapy consisted of paxaex treatment, and intravenous papaverin. The patient appeared somewhat sensitive to dicumarol the total dosage required of 12 days' period of therapy, being only 550 mgs. She had been on a maintenance dosage of digitalis for many months before the onset of the embolus. Recovery was uneventful and no further emboli have occurred since discharge a year ago.

#### Case 7

W. M. H.—age 42. Entered the hospital with a typical attack of acute coronary thrombosis and auricular fibrillation. He appeared critical-

ly ill during the early part of his illness. Because of his rapid fibrillation, the patient was given nine grains of digitalis on the sixth day of his admission but the drug was discontinued after 24 hours because of toxic symptoms. On the day following the discontinuance of digitalis, he first showed signs of pulmonary infarct. This infarct was followed on the next day, that is the ninth hospital day, by moderate pain in his right calf and foot, and mottling of the skin on the foot. The dorsalis pedis pulse, however, appeared normal and his symptoms subsided after a few hours. On the fifteenth day he suddenly developed signs of massive arterial occlusion of his right leg. Because of the precarious condition of his heart, continuous intravenous heparin appeared contra-indicated. Dicumarol was given orally. Good levels of prothrombin depression were not obtained for three days.

Meanwhile, the condition of his leg deteriorated rapidly, gangrene occurred and a mid-thigh amputation was performed 12 days after the onset of the embolism. When the amputation was considered, the dicumarol was discontinued. The total dosage for five days was 800 mgs. The prothrombin time remained elevated for three days after the discontinuance of the drug. Consequently, patient was given 64 mgs. of medanione intravenously,<sup>23-26</sup> and the prothrombin time fell from 27 seconds (25 per cent of normal), to 60 seconds (80 per cent of normal), five hours after the administration of the drug. When the prothrombin reached normal levels, amputation was performed. On the fifth postoperative day, the patient developed typical signs of arterial embolism of his left leg.

On this occasion, therapy was commenced immediately with large doses of heparin, 100 mgs. in 10 cc. given intravenously by the multiple syringe method every four hours. The more economical drip method of heparin was deemed unadvisable because of the signs of myocardial infarction. The clotting time was maintained at 10 to 12 minutes, capillary method, and dicumarol was administered by mouth, simultaneously. The prothrombin time reached 27 seconds (25 per cent of normal) in 3 days. On the third day the heparin was discontinued and dicumarol was then continued for another 16 days. During this 16-day period, the patient was continually digitalized because of the rapid fibrillation. In spite of digitalization, he developed no new embolic phenomena. Recovery was uneventful and the patient was well six months after discharge.

Recent work has shown a close correlation between the administration of digitalis and the acceleration of blood coagulation.<sup>36-40</sup> The patient's first episode followed the administration of digitalis, but the two in this case can not definitely be associated, since the second embolus occurred long after the drug had been discontinued. The failure of therapy and amputation of the leg might have been avoided if anti-coagulant therapy with heparin had been commenced immediately at the onset of the symptoms. It is possible that the second amputation was avoided by the immediate use of heparin. De Takats<sup>39</sup> has recently described a similar series of cases of arterial emboli which he believes were associated with administration of digitalis. Gefter<sup>19</sup>



has used dicumarol in 10 cases of major arterial occlusion with encouraging results.

#### Case 8

R. K. was a 62 year old diabetic, with peripheral vascular sclerosis. Six weeks before admission, she developed a saphenous thrombophlebitis of her left leg. Four days before admission, she developed sudden signs of arterial occlusion of her right leg. On admission, the fifth toe of the right leg showed early gangrene. The right leg was cold and mottled; the left leg still showed evidence of phlebitis. Neither dorsalis pedis pulse was palpable. The electrocardiogram showed a wandering pacemaker with nodal rhythm. The De Takats test<sup>29</sup> was markedly flattened, indicating an accelerated tendency to coagulation. A total of 1,200 mgs. of dicumarol were given in 12 days. Four days after the discontinuance of the therapy, the De Takats test approached normal levels. The gangrene of the toe disappeared, the edema diminished, and the patient is well seven months after discharge.

Bramble, Locker, and Ford<sup>10</sup> have reported the use of dicumarol in three cases of diabetic gangrene of the toes with good results, and it has also been used at the Mayo Clinic in a series of 18 cases of various types of peripheral vascular disease, but no conclusions were reached in this series. The consensus is that anti-coagulant therapy, particularly heparin, at the onset of symptoms in arterial occlusion is indicated in all such cases either with or without embolectomy. The prognosis in such cases, particularly when the embolus is large, is often poor.

#### REVIEW OF THE LITERATURE

Barker administered dicumarol to 624 surgical patients at Mayo Clinic.<sup>7</sup> During the immediate postoperative period, 111 of these patients had had pulmonary embolism or infarction and had survived. In only two of these cases were there any subsequent emboli encountered, and in both of these cases, the prothrombin time was not adequately elevated. No fatal emboli occurred in the entire group of cases to which dicumarol was administered. Barker et al.,<sup>41</sup> have found by statistical studies that in cases of pulmonary embolism, in which the patients survived the first episode, the chance of subsequent thrombosis and embolism during the next few weeks was 44 per cent. A third embolism subsequent to this, followed in 30 per cent and a fatal embolism 18.5 per cent.

Lam,<sup>15</sup> in discussing the use of anti-coagulants, showed statistically that in patients who had had one or more emboli, the anti-coagulant therapy reduced the expected mortality rate from 11.8 to 3.3 per cent in his series. Barker<sup>7</sup> also gave dicumarol to 83 patients, with postoperative thrombophlebitis. The statistical expectation of thrombosis and emboli in this group is 31 per cent and fatal embolus 5 per cent. Further thrombosis developed in only two of this

large series, and embolism did not occur in any group. Evans<sup>7</sup> using combined heparin and dicumarol therapy, observed only one benign and no fatal emboli in 56 carefully studied patients.

Zucker<sup>9</sup> reported the successful use of dicumarol in nine cases of thrombophlebitis with no central extension of the thrombosis and uneventful recovery. Lehman<sup>13</sup> using dicumarol in 60 cases of thrombosis of the extremities, believed that the therapy shortened the period of morbidity and diminished the number of complications. A series has also been reported by LeFevre, and McRoberts.<sup>16</sup>

Wassermann and Stats<sup>11</sup> reported the use of dicumarol in 17 cases of pulmonary infarction and embolism and nine cases of thrombophlebitis. These results were not always favorable for they reported several instances in which embolism occurred and thrombosis progressed in spite of good levels of prothrombin concentration. This has not been our experience except in one case of subacute bacterial endocarditis. Bingham, Meyer, and Howard<sup>14</sup> gave dicumarol to 105 patients and found it to be satisfactory and safe. Rhodes, Panzer, and Walker<sup>27</sup> reported the use of heparin intermuscularly combined with dicumarol in 13 cases of thrombophlebitis and two of pulmonary embolism. References have already been made to their work. Pfeiffer and Sain<sup>18</sup> reported the combined use of heparin and dicumarol in a small series of cases with good results. Geffer<sup>19</sup> has used dicumarol in thirty cases with success. Recently, Davis and Porter<sup>42</sup> reported the successful use of dicumarol in forty-three cases of postpartum thrombophlebitis with no hemorrhage in any case.

It is the consensus of most that such therapy definitely diminishes the incidents of pulmonary emboli and shortens the period of morbidity from deep thrombophlebitis.

#### DISCUSSION

When the cases in Table I are considered in the light of the experience of others, the fact that no patient in the entire group died of pulmonary embolism, seems to have some significance. It would appear from a careful study of all the cases of thrombophlebitis treated with anti-coagulant therapy, that there is a definite shortening of the duration of the illness, and fewer complications. The center of discussion at present in the treatment of thrombophlebitis seems to be concerned with ligation, as opposed to anti-coagulant therapy. Allen,<sup>43</sup> one of the chief advocates of surgery, has reported a large series of 202 cases with no deaths from pulmonary embolism in his group. Veal,<sup>44</sup> likewise reported the successful use of surgery in many cases. It seems that anti-coagulant therapy should be given a trial before its wholesale condemnation by surgeons.

For an impartial discussion of the whole mat-



ter, one is referred to a recent review of Homans.<sup>45</sup> Certainly, the "do nothing school" of therapy seems outdated as we are learning of the serious complications of embolism. The most satisfactory method of treatment whether surgical or medical, that is with anti-coagulants, will probably only be settled by a large series, using alternate cases. As our interest in thrombosis and emboli increase, we are becoming more interested not only in its etiology but its prevention, possibly by early exercise or rising,<sup>46-48</sup> and by early detection by clinical and laboratory methods.

The chief advantage of dicumarol is its inexpensiveness, its ease of administration orally and its prolonged effect. Its disadvantages are the large variations in its effective dosage, and its tendency to produce hemorrhage in a certain percentage of cases no matter how carefully controlled. Although medianone in large doses counteracts the hemorrhagic effect of dicumarol, it appeared ineffective in one of our cases.

Davidson<sup>49</sup> believed that dicumarol is a poor substitute for heparin. However, Dale, and Jacques,<sup>50</sup> Richards and Cortell,<sup>51</sup> Thrill<sup>52</sup> and his associates have proved experimentally that dicumarol will prevent venous thrombosis. The chief advantage of heparin is the rapidity of its anti-coagulant effect so often necessary after recent embolic phenomena, and its relative safety if carefully controlled with clotting time. Its present disadvantages are excessive costs and the need for the most effective results to administer it intravenously. If the rapid effect of heparin is needed and the more prolonged effect of dicumarol is indicated, the two drugs may be used simultaneously, always remembering that the effect of the dicumarol must be studied by daily prothrombin time determinations, while the anti-coagulant action of heparin must be followed by determinations of the clotting time at frequent intervals. It is probable that the newer preparations of heparin will remove some of its chief disadvantages, its expense and the need for its intravenous administration, and thus broaden the multiple uses of anti-coagulant therapy. Loewe<sup>53</sup> has reported the use of subcutaneous heparin in a special mixture, in fifteen cases of deep phlebitis with satisfactory results. Myerson and Code have reported the use of heparin in a special beeswax mixture.<sup>54</sup>

#### SUMMARY OF RESULTS

1. Of the total of 33 cases of Table I, no new infarct developed in nine cases of phlebothrombosis in which infarction was the signal episode often preceding evident signs of thrombosis by three to five days. I consider this group the most important because it is in this group that the mortality is usually the highest. Signs of infarction in this group usually preceded the throm-

bosis by several days. Sometimes the phlebothrombosis was followed by typical thrombophlebitis or again the thrombosis was minimal. It should be emphasized that the prognosis is always more serious in this group.

2. No new infarcts developed in four cases of frank thrombophlebitis, of various causes, which had previously been associated with infarction. In this group, the signs of phlebitis usually antedated the infarct by one or more days.

3. No new infarct developed in any of our remainder of twenty cases of simple deep thrombophlebitis.

4. It was the general clinical impression that the duration of the thrombophlebitis was definitely diminished by the treatment. Pain often disappeared three to four days after the beginning of therapy, although some edema might persist for as long as two weeks after all therapy had been discontinued. Three patients examined one month after discharge from the hospital, had slight residual edema. The nursing problems were definitely diminished since the patients were gotten out of bed as soon as their prothrombin concentrations had fallen to satisfactory levels, usually by the fourth or fifth day.

5. In the series of Table I, one case may be considered a frank failure because of the recurrence of three episodes of thrombophlebitis. Two other cases had mild recurrences of thrombophlebitis which responded well to a second course of therapy, a total recurrence rate of 9 per cent.

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# Anatomic and Physiologic Principles Underlying Plastic Surgery of the Nose

RAYMOND S. ROSEDALE, M. D.

THE purpose of rhinoplasty is being clarified to the otolaryngologist, but to some specialists in other fields and to some general practitioners it continues to be a mysterious procedure.

## THE PRINCIPLES UNDERLYING RHINOPLASTY

Rhinoplasty came to the attention of the public and physicians in general after the last war. It had been vaguely recognized prior to that time but it was generally regarded that only a few people in the world, chiefly among whom was Joseph of Vienna, could be capable of doing this work. The former prevailing austere impression that one had to have an inherent ability for this work, or must possess artistic judgment and the fingers of a sculptor, prevented many physicians from inquiring into the field. This limitation of knowledge was aggravated by the observation that those who were acknowledged to be leaders in the field of plastic surgery did not freely disseminate their knowledge to others. These conditions plus the mysterious aura generated by unethical "beauty" surgeons with gilded accounts of their accomplishments have raised a mental barrier in the minds of many practitioners, which would disappear if they understood the basic anatomic, physiologic and surgical principles employed in this field. The increasing amount of attention being given to the subject of rhinoplasty by the otolaryngologist and general plastic surgeons, together with the development of some intriguing new concepts, caused the author to feel that the subject might be of timely interest to others. Not that all those who read the article may be expected to perform rhinoplasties, but rather it is hoped that if the underlying principles of a relatively little known field can be presented in a simple understandable fashion, their interest may be increased.

## ANATOMY

To establish a common ground for clarity of discussion, the structure of the nose will be reviewed from the rhinoplastic surgeon's point of view.

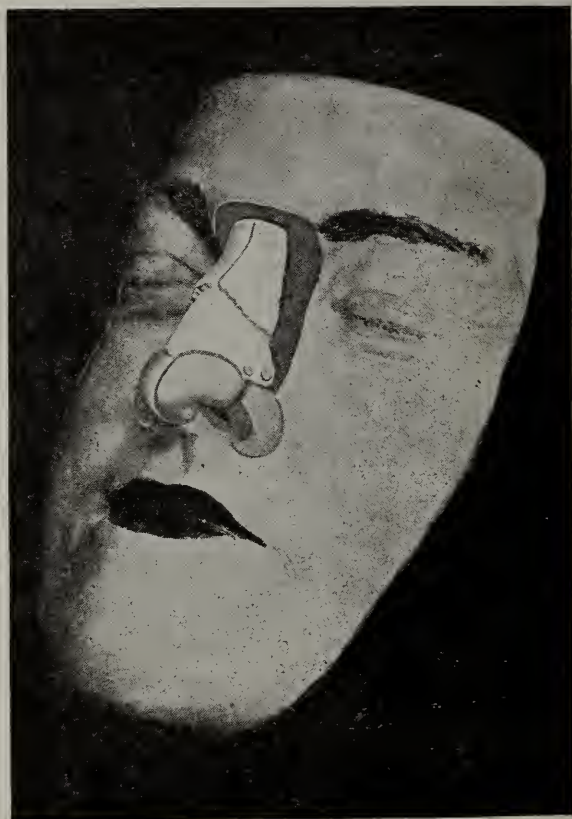
The skeleton of the nose consists of three pyramids superimposed on one another. Above, the column of pyramids is locked into the nasal spine of the frontal bone and to the frontonasal suture. Below, the column of pyramids is attached to the anterior nasal spine of the maxillae, and indirectly to the pyriform opening. The

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upper pyramid, the bony vault of the nose, composed of the conjoined nasal bones, rests laterally on the maxillae at the naso-maxillary suture.

The middle pyramid consists of the upper lateral cartilages, an interesting conjunction of



No. 1. Photograph of an original model made by the author to illustrate the relationship of the three pyramids of the nose.

This shows: The upper pyramid composed of the nasal bones. The middle pyramid composed of the upper lateral cartilages. The lower pyramid composed of the lower lateral cartilages. Note the mesial and lateral crura of the lower lateral cartilages.

two upper lateral wings which constitute a part of the cartilaginous vault of the nose. Mesially, the junction of these cartilages is continuous with, and an integral part of, the cartilaginous





No. 2. Photographs of lateral view of a patient with external deformities of the nose associated with nasal obstruction due to deviation of the nasal septum. Preoperatively, note nasofrontal angle of 38 degrees (hump), and saddle at the level of the middle nasal pyramid. The septolabial angle is too acute, viz., 80 degrees. Also note the relatively short lip. Postoperatively, note the loss of the hump. Now there is a normal nasofrontal angle of 31 degrees. Note the straight dorsum. This has been accomplished by removing the hump and grafting it into the saddle over the dorsum of the middle nasal pyramid. The septolabial angle is now 94 degrees. The upper lip is longer. Note the shortening of the nose.

portion of the nasal septum. The middle pyramid, or upper lateral cartilages arise from well under the upper pyramid or nasal bony arch. Laterally, the cartilages are attached to the connective tissues arising from the lateral aspect of the pyriform opening.

Both the upper pyramid and middle pyramid contribute to the ventral and lateral proportions of the nose. The lower nasal pyramid is cartilaginous in nature. It arises laterally from the connective tissue aponeurosis which anchors it to the lower part of the lateral portion of the pyriform opening. A cartilaginous wing on either side sweeps in and bends sharply in itself, forming a horse-shoe. The lateral arms of the horse-shoes are called the lateral crura and the mesial arms, the mesial crura. The combined mesial crura constitute the cartilaginous portion of the columella. The form of the lower lateral cartilages determines the size and position of the vestibule of the nose and the configuration of the lobule.

The cartilaginous nasal vault is self supporting for ordinary stresses. The nasal septum can be considered from a structural point of view as being non-supporting except in the cases of unusual strain. Only in those instances where the mesial aspect of the lower border of the lower lateral cartilages flare away from the mid-

line, can the septum be considered as supporting the dorsum of the nose under ordinary conditions. In such examples only may a saddle nose follow removal of all the septal cartilage in doing a submucous resection of the septum. The elastic properties of the skin of the nose permit it to cloak itself about the underlying skeleton work.

Much has been written about the physiology of the nose. Proetz's authoritative book deals in some detail with the physiology important to the otolaryngologist. From the rhinoplastic surgeon's point of view there are certain practical points which should be emphasized. The nasal inspiratory pathway does not follow the floor of the nose, but describes a broad arch from the nostril through the olfactory sulci to the choanae. A simple experiment emphasized by Fomon, the distinguished and eminent teacher of rhinoplasty, demonstrates this point. If the reader will pinch in slightly the sides of the nose in the region of the upper lateral cartilages he will notice that nasal inspiration is impeded even though the nostrils and pathways in the region of the inferior turbinates are patent.

The size and position of the nostrils must be considered in the subject of nasal inspiration. The choanae being larger than the nostrils there



No. 3. Photographs of the frontal view of the same patient. Note the improved appearance of the lobule following the removal of the angle of the lower lateral cartilages. Note the narrowing of the base of the nose and its straighter axis. The improvement of the facial expression is evident.

is a definite difference in pressures between these two points, the smaller the nostril the greater the nozzle or pressure effect and the greater the velocity of the inspired air. This practical point in nasal physiology is basic to the rhinoplastic surgeon. Proper evaluation of the size of the nostril will determine whether or not its opening should be altered to improve breathing.

An increase in width of the base of the columella can impede the intake of air at the vestibules, and, conversely narrowing the base of the columella may improve it. Narrowing the base of the columella with the prongs of the bayonet forceps is an office experiment which will determine this point. Likewise, the angle of presentation of the nostrils affects nasal breathing. As an example of this, many physicians have heard patients state that when they hold the tip of the nose up, they breathe better. Since the air passes from the nostrils to the choanae, it is obvious, that when all other factors are equal, if the nose is shortened, nasal breathing will be improved since the air has a shorter distance to pass through the nose. The function of the gliding motion of the upper lateral cartilages over the lower lateral cartilages, and the action of the muscles of the nose in relation to breathing and their consideration of the rhinoplasty will not be considered except to state that their functions must not be disturbed by the rhinoplasty.

#### REASONS FOR OPERATION

Rhinoplasty may be performed to improve cosmetic appearance, the function of the nose, or for both reasons. Internal deformities of the nose such as deviation of the nasal septum are not infrequently associated with external deformities such as lateral deviations, humps, saddles, twisted tips, widening of the base of the columella, hanging nasal tip, etc. With advances of technical knowledge one can straighten and reposition that nasal septum with more exactitude and greater ease when doing a rhinoplasty than when submucous resection of the septum is done as an isolated procedure. This is especially so with deviations of the anterior cartilaginous portion of the septum, a condition which, until the combination with rhinoplasty, has always been difficult and unsatisfactory.

Rhinoplasty for cosmetic purposes should be confined to mentally stable individuals who can offer a good reason for desiring a change in the appearance of the nose. Should there be any question of schizophrenic tendencies in the patient, the operation should not be done without the advice of the psychiatrist.

A rhinoplasty is always carefully planned before its execution. The septolabial angle (ideal, 90-105 degrees), the nasofrontal angle (ideal, 33-38 degrees), the width of the nose, its length, the width of the base, the width of the columella,





No. 4. Photographs of the base of the nose on the same patient. Note the change in the shape of the nostrils and the narrowed columella. Nasal breathing was normal after the operation.

the size of the nostrils and their configuration, deflections of the entire nose, the condition of the septum, all must be considered. As well as this, the length of the nose and its relation to the contour of the face are important. If the upper lip is unduly short the rhinoplasty should be planned to lengthen the lip. If the chin is unduly recessive, one may plan to increase its projection by grafting the removed hump into it. In reconstructing losses of tissues, one will have to plan the type and source of material for grafts. The importance of nasal function must be considered at all times. It should never be impaired. Most of the time it will be improved.

#### PRINCIPLES OF THE TECHNIQUE OF THE RHINOPLASTY

Operations should not be done in those who have not reached their full growth except under special circumstances. Active infections of the nose are contra-indications to operation. Prior to the operation the vibrissae are clipped. The skin of the face is scrubbed with green soap, alcohol and then ether. The vestibules are treated with a mild antiseptic. Preoperative medication is three grains of seconal plus one quarter of morphine. The patient is carefully draped under sterile covers, leaving the prepared face exposed. Perfect anesthesia is obtained with cocaine-adrenalin solution applied to the interior of the nose and the blocking of the infratrochlear, ex-

ternal nasal, infraorbital and anterior nasopalatine nerves with 1 per cent novocaine.

The dorsal part of the nose is packed lightly with gauze. All incisions are made inside the nose, the first being between the upper and lower lateral cartilages on either side. The skin and periosteum are elevated with respect for anatomical planes. A transfixion is made between columella and the mesial crura. In effect the nose is skeletonized so that one has direct vision of its components. With this accomplished, the reconstruction of the nose depends upon the surgical judgment and knowledge of normal anatomical and functional relationships on the part of the surgeon. Humps may be sawed off to reduce the prominence of the dorsum. Saddle defects may be repaired with costal cartilage or with cancellous bone from the iliac crest.

The upper nasal pyramid composed of the nasal bones may be narrowed by sawing through the naso-maxillary junction in the region of the slight fossa that is found ventral to the lacrimal fossa. Narrowing of the upper nasal pyramid should always be done after removing a hump, otherwise an unsightly flattened dorsum will remain. The middle nasal pyramid composed of the upper lateral cartilages may be narrowed by removing some of their mesial borders. The upper lateral cartilages may be shortened by removing some of their distal ends. The mesial borders of the upper lateral cartilages may be

sewn to one another to reinforce the vault of the middle nasal pyramid. Where there is a slight saddle in the dorsum of the middle nasal pyramid, this may be overcome by everting the mesial ends of the upper lateral cartilages and sewing them together in this position. The lower nasal pyramid may be altered by skeletonizing the lower lateral cartilages and trimming them to meet the desired contour. Vestibular skin is never sacrificed. By reducing the width of the lateral crura of the lower lateral cartilages the width of the lobule is reduced; by reducing the length of the mesial crura the projection of the nose is decreased. The size and shape of the nostrils may be changed at this time.

#### THE AMPUTATION

The primary shortening of the nose is accomplished by amputating the desired amount of the distal end of the freed cartilaginous septum. As the operation nears completion the columella and distal end of the septum are reattached by silk sutures in such a manner as to elevate or depress the tip. "Clocking" sutures are frequently employed. A short upper lip can be made longer at this time by advancing some of the lower part of the columella into the lip and fixing it there. Ordinarily no sutures are used in the union of the divided cartilaginous ends. Buttons of either fresh or preserved cartilage are used to elevate depressed areas or to round out flattened areas.

If a submucous resection is contemplated with the rhinoplasty it is best done by elevating the mucoperichondrial flaps from the cut distal ends of the cartilaginous septum. As much of the septum as desired may be removed. One or two pieces of straight cartilage are placed between the flaps to prevent subsequent contractures which mar the conventional submucous resection. Also a "stiffening" piece of cartilage is sewn into a pocket of the membranous part of the septum. By combining the submucous resection with the rhinoplasty, a better septum result is obtained.

At the completion of the rhinoplasty the packs are removed and a piece of dental stent applied over the dorsum of the nose. The operation should not be terminated until the desired result is obtained. If the structural result is not good immediately after the operation, it certainly will be no better when the wound is healed.

The patient is kept in the hospital two or three days. At the end of five days the patient can return to work. The sutures are removed after the fifth day. Swelling of the face, and discoloration around the eyes, when they occur, usually disappear within 10 days.

The final evaluation of nasal function and structure can be made at the end of a six-week period, although the improvement of these continues for about a year.

#### KEEPING UP WITH MEDICINE

**T**HE impairment of renal metabolic function is the important factor in conditions such as uremic azotemia and acidosis.

\* \* \*

**I**T is about time that some of our leaders began to take notice of the great expense to which the public is put for the collection of records, tests, recording, and tracing that may have value to the teacher or the researcher but are only a "show" for the ordinary patient and increase the cost of medical care tremendously. Let's get honest in such matters.

\* \* \*

**H**YPERPLASTIC sinusitis is primarily a nasal allergy on which secondary infection has been engrafted; deep pain referred to a distance is the rule. Those cases of myalgia without the usual criteria of allergy are often instances of physical allergy. Williams of Rochester is recommending the exhibition of nicotinic acid.

\* \* \*

**M**ANY case reports are coming in which illustrate clearly the necessity for an allergic history and careful skin testing prior to the administration of egg or chicks to the vaccines.

\* \* \*

**W**HEN this warning is ignored some occasions occur in egg sensitive individuals. Egg or chick containing vaccine includes the following: Typhus, encephalomyelitis, Rocky Mountain spotted fever, influenza and yellow fever vaccines.

\* \* \*

**S**URVEYS of the whole population by mass X-rays for the detection of tuberculosis is showing that about one per cent of the people at any one time have reinfection tuberculosis.

\* \* \*

**O**CUPATIONAL dermatitis among air craft workers is accounted for in 65 per cent of cases by zinc chromate. Seventeen per cent are due to resin and 15 per cent to both, according to Dr. Hall's experience.

\* \* \*

**T**HE bulk of the evidence indicates that a positive skin with Brucella antigens means past contact with any of the Brucella organisms, but a negative skin test does not necessarily rule out the infection.

\* \* \*

**O**NE of the best rules in the management of athlete's foot is not to over-treat. It is bound to die out if there are no dead cells in which to grow. Keep clean and wait.—J. F.



# Adrenal-Sympathetic Syndrome Associated With Paraganglioma of Organ of Zuckerkandl\*

E. F. KOSTER, M.D.

**Case History.** E.M., a white female 34 years of age, entered Cleveland City Hospital Aug. 24, 1943. Beginning in 1940 the patient experienced episodes of headache, nausea and vomiting, insomnia, irritability, flushing and sweating with moderate prostration. These episodes slowly increased in severity and frequency. There was questionable correlation with menses. Menstruation had been increasing in frequency and severity, recurring at intervals of 2 weeks for several months preceding admission. Weight had remained constant at 130 lbs. She had completed 10 pregnancies. In 1940 she had a bilateral salpingectomy, left oophorectomy and appendectomy.

**Examination** on admission revealed an apprehensive, hyperactive, acutely ill, well developed and well nourished white female. The patient was persistently nauseated and vomited during the examination. She was sweating profusely and the skin of her head, upper trunk, arms and lower legs was flushed. The neck was rigid. Precordial activity was increased but the heart sounds were normal and there were no signs of cardiac enlargement or decompensation. The lungs were clear to auscultation and percussion.

The temperature was 37.2° C., pulse rate 120, respiratory rate 28 and blood pressure 210/110. The red blood count was 4,980,000 per cu. mm. The white blood count was 4,200 per cu. mm. with 92 per cent neutrocytes and 8 per cent lymphocytes. Specific gravity of the urine was 1.023. Qualitative examination for albumin was 4+ and was negative for sugar. Microscopic examination of the urine revealed 3 to 5 white blood cells per high power field, no red blood cells and no casts. The spinal fluid pressure was slightly increased and the fluid itself was grossly bloody. The blood urea nitrogen was 26.3 mg. per 100 cc. Neurological examination revealed the right pupil to be larger than the left. The patient was able to move all extremities. The reflexes were generally decreased and the Babinski reflex was positive on the right.

During the first 24 hours of admission nausea persisted, urination was involuntary and the temperature gradually rose to 40.2° C. During the second hospital day the blood pressure was 190/100. Fundoscopic examination revealed bilateral papilledema, venous engorgement and slight increase in light streaking of the arteries. The right extremities became flaccid. The patient became progressively more lethargic and during the last 12 hours of life was comatose. She died 36 hours after admission to the hospital.

The clinical diagnoses were: Subarachnoid hemorrhage; malignant hypertension with arteriolar nephrosclerosis.

**Autopsy** (No. 15118) disclosed an extensive recent subarachnoid hemorrhage which was pronounced over the base of the brain. Serial gross sections of the brain showed no internal lesions.

\*Selected by H. T. Karsner, M.D., from the Clinical-Pathological Conferences at Cleveland City Hospital as the twenty-eighth of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

Loosely adherent fresh blood clots were found in the lateral ventricles. The third and fourth ventricles were filled by dark reddish-brown clots. Examination of the arteries and veins in the leptomeninges revealed no localized lesions and the bleeding point was not found.

Immediately caudal to the renal arteries and attached to the anterior surface of the aorta was a rounded, encapsulated, moderately firm mass measuring 4 x 3 x 2.2 cm. The capsule was roughly 1 mm. in thickness and the substance was homogeneous yellowish-brown and moderately firm. The para-aortic lymph nodes in this region were identified, but were not remarkable. There was also hypertrophy (375 gm.) of the heart, slight coronary arterial sclerosis, moderate arterial and arteriolar sclerosis of the kidneys, moderate fatty metamorphosis of the liver, moderate arteriolar sclerosis of the liver, acute bronchitis and an intramural fibromyoma of the uterus.

Microscopic examination of portions of the tumor fixed in Wiesel's, Mueller's and Zenker's fixatives reveals it to consist of small groups of large polyhedral cells (approximately 30 to 50 per group) separated in most areas by a very delicate connective tissue stroma containing capillaries. There is abundant finely granular cytoplasm which is pale pink in about 50 per cent of the cells while in the remainder it is pale brown. The cell margins are indistinct. The nuclei are large, ovoid, slightly eccentric and vesicular. They appear to be twice the size of a neutrocyte. The nuclear membrane is prominent. There is a relatively small amount of fine chromatin material in the nuclei. Nucleoli are readily visible but are small, stained deep blue and vary from 1 to 3 per nucleus. Mitotic figures are rarely encountered. Small foci of necrosis are scattered through the tumor. There is no inflammatory reaction. The capsule reveals no evidence of invasion and is formed by fibroconnective tissue. The sections were stained by the routine hematoxylin and eosin method and by the method of Schmorl.

## COMMENT

Tumors developing in chromaffin tissue are variously called pheochromocytoma, paraganglioma and chromaffinoma. The first term is usually chosen to represent this type of tumor when it involves the adrenal medulla. Paraganglioma is used to denote any one of the extra-adrenal sites. In this case the location of the tumor corresponds to the location of the organ of Zuckerkandl. Goldzieher<sup>1</sup> states that the associated syndrome of paroxysmal hypertension is responsible for the increased recognition of tumors of this type in recent years. Brunschwig and Humphreys<sup>2</sup> collected 13 cases. The bifurcation of the aorta, apparently coincident with the place of Zuckerkandl's organ, is the commonest site of paragangliomas.

This case demonstrates the fatal outcome of



this type of tumor when not diagnosed and treated. It also serves to remind the internist and surgeon of this possible location should perirenal air insufflation or exploration fail to locate an adrenal tumor.

The symptoms of this patient are the same as those produced by periodic discharge of adrenalin or an adrenalinlike substance into the general circulation. Such a pressor substance in this type of tumor was first demonstrated by Beer, King and Prinzmetal<sup>3</sup> and it has been confirmed repeatedly. Hyman and Mencher<sup>4</sup> have discussed the pressor response. They state that attacks may occur spontaneously or be induced by emotional upsets, fear, anger, slight trauma, change in posture, physical exertion, massage of the tumor or immersion of the extremities in cold water. In this case there was clinical evidence of a relationship between the menses and the onset of the attacks. It may be that the emotional disturbance associated with the onset of menstruation acted to induce attacks. The menstrual irregularity may have been a result of the uterine fibromyoma.

One problem in this case is the associated moderate degree of renal arteriolar sclerosis. This makes it difficult to say whether the hypertension was due to the tumor or to renal disease. There were no blood pressure readings made during or between attacks. Therefore, the existence of hypertension of renal origin can not be denied. Palmer and Castleman<sup>5</sup> refer to this same problem. They say the true hypertensive crisis is commonly preceded by prodromes while the sympathetic syndrome starts suddenly without prodromes. Mackeith<sup>6</sup> mentions the marked prostration which characterizes the end of a sympathetic syndrome. This was repeatedly noted in the case reported.

Duncan, Semans and Howard<sup>7</sup> reported a case of adrenal pheochromocytoma in a patient with diabetes mellitus. Following surgical removal of the tumor her diabetes disappeared. Others have noted the association of neurofibromatosis. This case demonstrates neither one of these accompanying disorders.

It is interesting to note the ease with which this tumor might have been removed. Although firmly attached to the aorta, it could have been dissected free without great difficulty. In this site it is not necessary to remove adrenal cortical tissue or an entire kidney which has been frequently necessary in the adrenal sites.

#### SUMMARY

A rare example of a benign paraganglioma of the organ of Zuckerkandl associated with the adrenal-sympathetic syndrome is presented.

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### Coronary Outlook

The individual with so-called angina of effort who probably has had a closure of a coronary twig, with a minor, circumscribed myocardial infarction—of relatively small size, has a good "outlook" both as regards potential longevity and energy quotient. His physical and mental activities call for little if any curtailment. Certain types of occupation which demand unusually strenuous physical effort are naturally contraindicated, and are incompatible with well being and safety. And there are some exceptions, a minor percentage, however, which will demand restriction of even the average exertion essential to livelihood. However, the vast army, of early or mild coronaries can carry on the average occupation with safety and euphoria. The same statement covers the matter of physical exercise. An individual who has played golf for decades, may continue to do so (on a flat course and under ordinary circumstances).

Walking (leisurely) and swimming, rowing, bowling, in a word—the ordinary types of physical exercise to which a patient has become familiar—are neither contraband nor hazardous. The more strenuous forms of exercise such as running, tennis, etc., are naturally not permissible.—Robert S. Berghoff, M.D., Chicago; *Ill. Med. Jr.*, Vol. 87, No. 6, June, 1945.

### USING WORDS CORRECTLY

Physicians should speak and write correctly, and all of us slip into bad usage at times. We mispronounce words, resort to medical jargon, or indulge in obsolete usage. May I call attention in this brief paragraph to a group of words which we frequently mispronounce?

|                 |                 |
|-----------------|-----------------|
| cerebral        | ser'e-bral      |
| duodenum        | du-o-de'num     |
| abdomen         | ab-do'men       |
| atypical        | ah-tip'ik-al    |
| dilatation      | di-la-ta'shun   |
| acetylsalicylic | as'-et-il       |
| salicylate      | sal'is-il-ät    |
| chemotherapy    | kem-o-ther'ap-e |
| hepatopathy     | hep-at-op'ath-e |

—R. G. LEHMAN, M.D.



# Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

## THE PRIVATE PRACTITIONER AND THE INDUSTRIAL PHYSICIAN

The objective of the private practitioner is to fulfill the duties of his profession in getting the patient well. The physician has another interest, and that is to demonstrate the value of the private practice of medicine. This also has a financial aspect to the physician. The fight against tuberculosis can not be won without the participation of the private practitioner of medicine.

The industrial physician on his part has at least three objectives: (1) The protection of all employees against open cases of tuberculosis; (2) the protection of the so-called arrested tuberculous patient from his own over-activity or poor judgment; and (3) the protection of the industry itself from financial loss in attempting to convert the tuberculous patient into a wage earner.

All are well aware of the validity of the first two points. The last point becomes significant when one hears that by some courts "aggravation of tuberculosis" is held compensable.

With due respect to the interests of the three parties mentioned above, what is to be accepted as evidence that a tuberculous patient is employable? (1) First and foremost is a series of X-rays demonstrating that the lesion is static or regressing under the conditions of living undergone by the patient during that period of observation. (2) It is essential that this period of observation covered by the serial X-rays include eight hours at least of daily activity, even though of light or moderate degree. (3) There must be an adequate series of negative sputum examinations. The author personally prefers a minimum of three consecutive negative sputum examinations, or, preferably, gastric aspirations. (4) An obvious increase in the feeling of well-being of the patient, such as complete absence of symptoms and a satisfactory weight history, is important. (5) A blood sedimentation rate has been found to be worth while, and hence at least one normal blood sedimentation rate should be insisted upon. (6) A daily record of the temperature at 4:00 p.m. and 8:00 p.m. for an immediate period of 10 days should be established. (7) There must be developed in the patient a proper attitude toward his own condition and a proper understanding of just what this trial-and-error period means in the way of mutual cooperation. By proper, "humble" or one of forfeiture of any rights is not meant. What is meant is good insight and a paramount will to get well. (8) Finally, there must be an available job which the applicant can do and may do without causing real

or alleged damage to himself, or creating a menace to his fellow employee.

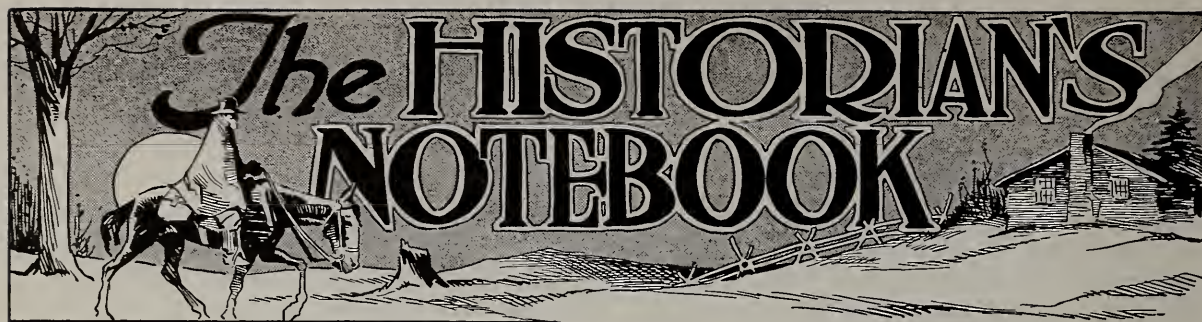
In order to achieve this, there must be a system of restricted placement, and, in setting up such a system the medical status of the individual must be kept confidential so that the employee will feel reassured, and thus be helped to establish self-respect and regain confidence in himself.

No classification system can be followed blindly. Individual evaluation of each case is necessary and any preformulated procedure of restricted placement is nothing more than an overall guide. Such a restricted placement procedure must be revised constantly and kept up to date, and the health status of the individual must also be re-evaluated at regular intervals.

In connection with the re-evaluation, it may be worth while to discuss the author's manner of handling any one particular case. Whenever the routine pre-employment X-ray brings to light a lesion about which there is any question of activity, the applicant is refused employment until a thorough survey by his family physician or qualified agency is made available. Routinely, the author asks for: (1) Previous chest X-ray record, if any; (2) at least three negative sputum examinations and, where warranted, at least one negative gastric aspiration; (3) a ten-day, twice a day, temperature record; (4) the sedimentation rate; (5) written permission of the physician caring for the case that this person may work; (6) following this evaluation, another discussion with the patient exploring and improving his mental attitude; and, lastly, a reclassification, taking into consideration other restricting disabilities the employee may have.

Depending upon the indications of this re-evaluation, the employee is reviewed in one, two or three months, and, according to the indications, these re-evaluations are either increased or decreased in time frequency throughout the year or years. This procedure applies to the white-collar men as well as the group that wears overalls.—Cooperative Efforts of the Industrial Physician and the Private Practitioner in Re-employment of Arrested Tuberculosis Patients, J. F. Johnson, M.D., Industrial Medicine, Jan. 1945.

The tuberculosis mortality rate among males in practically all age groups shows a consistent relationship to size of community. The rate in large cities is considerably higher than in the intermediate-sized cities and the rate in the latter is in turn higher than that of the rural areas.—Jacob Yerushalmy, M.D., and Charlotte Silverman, M.D., Am. Rev. Tbc., May, 1945.



*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## Fifty Years of the Cleveland Medical Library

ROBERT M. STECHER, M.D.

THE year 1944 witnessed the Jubilee Celebration of the founding of the Cleveland Medical Library Association. In anticipation of this event considerable time and discussion were devoted to contemplation of the origins, accomplishments and future plans of the organization with the result that an unusual degree of interest was aroused and an extraordinary amount of activity was stimulated. The Director of the Library therefore has thought it proper to render a report more complete than has been his custom calling particular attention to the facilities of the library in the hope that its services will become better known and will be utilized by more Ohio physicians outside of the Cleveland area.

On December 31, 1944, the library contained 63,130 volumes, an increase for the year of 1,262 books. The registered visitors increased 256 over 1943, totalling 10,157. Of these, 3,393 were made by members, 2,901 by medical or dental school students, and 3,863 by others. Book loans amounted to 5,648 items, an increase of 190 for the year. Of the total, 742 were delivered free to 153 members. About 90 items were sent to Crile General Hospital on inter-library loan. The library received regularly 251 American and 72 British journals. The library had on subscription about 50 French, 106 German and 31 other European journals but these were being delivered irregularly if at all. Eleven new journals were added to the list during 1944.

The membership in the library on December 31, 1944, was 1,435, the largest in the history of the Association. This included 377 men in active military service, men who will be carried on our lists free of financial obligations to the library and who are assured of all of the privileges to which their membership entitles them, including free delivery service within the limits of

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continental United States. Their status and privileges as members absent on government service will continue until it is changed by order of the Board of Trustees after their return to civil life. Of the 1,058 members, 20 were Honorary Fellows and 7 Fellows for Life. There were 224 Fellows, 351 Associate Fellows, 13 Junior Fellows, 24 Affiliated Members, men not belonging to the medical profession, 16 non-resident members and 21 inactive members. The library also had 183 interne members and 199 student members.

This medical library in Cleveland started in the 1870's with the subscription to *The Lancet* which Dr. Isaac N. Himes sent to Case Library where members of the profession might read it. The Association as we now know it began at a meeting held November 27, 1894. At that time a committee representing three local medical societies adopted a constitution and by-laws. The fact that there were three competing medical societies in Cleveland at the time did not prevent the formation and the survival of a strong, independent and stable organization. The library was conceived in faith, but growth and development were maintained by adhering to the ideal of attaining a sound, substantial, practical col-



lection of books, properly housed and kept readily accessible to the practicing physician. The actual library was first housed in a segregated section of Case Library until a home of its own was provided on Prospect Street in 1898. These quarters served with additions and modifications until 1926 when the Allen Memorial Library, its present home, became ready for occupancy.

The Allen Memorial Library was so well planned twenty years ago that it still serves as a compelling inspiration to all who enter it, and it promises to fulfill adequately the practical, scientific and cultural needs of the medical profession for years to come. The task of designing the building, soliciting the funds and supervising the construction was possible only through the devotion of a small group of earnest men. The undertaking served to bind the local physicians together with a common bond and developed a unity of purpose which will continue to grow stronger.

The building was dedicated in 1926 by Dr. Harvey Cushing, at that time the Moseley Professor of Surgery at Harvard and a Cleveland son whose family had been native here for three generations. The address he delivered on that occasion was a classic which deserves to be read periodically by every librarian and library trustee. He defined very clearly what a library should be and should attempt to do. His description of the magnificence of the building, the beauty of its design, the adequacy, convenience and utility of its facilities, and the provisions for long term needs did much to develop a sense of pride and self-respect among the members and prepare them for things that were still to come.

The change of home and the change of habit was accomplished without serious disruption, and the Association continued to prosper despite a serious financial depression and a shrinking membership. Nothing of great importance occurred until 1929 when the library acquired by anonymous gift, through the efforts of Dr. E. H. Cushing, the then Director of the Library, the Nicolas Pol Library. This assemblage of 35 incunabulae was the largest collection of his medical works known to exist in the United States. The monumental gift warranted attention and brought distinction to the library. Several additions to the collection have been made since the original purchase. As part of the Jubilee Celebration the Trustees have authorized and provided for a comprehensive and scholarly study of the material leading to the eventual publication of a "Life of Nicolas Pol" and a descriptive catalogue of the collection. Dr. Max H. Fisch, of the Army Medical Library, has accepted responsibility for this task.

Another treasure of culture which may in time come to be recognized as an outstanding asset

of the Cleveland Medical Library is the Dittrick Museum of Culture and Historical Medicine, collected over a period of twenty years by the genius, devotion and energy of our present President, Dr. Howard Dittrick, and his wife.

A recent stimulating influence bearing upon the activities of the library has been the arrival of the Cleveland Branch of the Army Medical Library. Because of the fear of bombing and overcrowded conditions of the Surgeon General's Library in Washington, it was decided to move the incunabulae, the old and rare books, and the li-



The Lowman Room of the Cleveland Medical Library

brary of vital statistics to a less conspicuous target. The Trustees of the Cleveland Medical Library were happy to be able to furnish the Army with satisfactory quarters within their building without seriously interfering with its usual functions. By moving the Dittrick Museum into the south gallery, the only major dislocation incurred, the Army was offered and accepted the rest of the third floor. With wooden book shelves in the center exhibition hall and two top tiers of the library stacks, space was available for 60,000 volumes. Activities of the Cleveland branch of the Army Medical Library, now housed in our building, have expanded to such an extent that they now employ 18 people.

The opportunity to see frequently and fondle intimately this wealth of old books, this collection of famous treasures, concerning which all book lovers had heard so much but had rarely seen, proved a great stimulus to the Cleveland Medical Library members. It was an even greater privilege to meet and know Colonel Harold W. Jones, Librarian to the Surgeon General's Library, and his associates, Major Thomas E. Keys, Officer in charge of the Cleveland Branch, and



Dr. Max Fisch, Curator of Old Books, and the rest of the staff. Important library authorities who have come to Cleveland to visit our distinguished tenants have stopped to admire the Allen Memorial Library and to become acquainted with the Cleveland Medical Library. The Army Medical Library has shown its confidence in Cleveland men by appointing six of them, three our Library Trustees, to be Honorary Consultants to the Army Medical Library.

Since coming to Cleveland Major Keys has been elected Editor-in-Chief and Dr. Fisch, Assistant Editor, of the *Bulletin of the Medical Library Association*. Under their direction this journal has been expanded in size and scope. The editors have commissioned various authorities among members of the library, the Western Reserve University faculty, the curators of the Cleveland Museum of Art and the Cleveland Health Museum, and the library staff to produce literary, artistic, cultural and historic studies with medical connotations for the journal. As a result, medical literature has been enriched by Cleveland ability which might otherwise have been unrecognized.

One other important project springing from the Army Medical Library has an important part of its activity in Cleveland. This is the revision of Gould's Medical Dictionary with Colonel Jones as Editor-in-Chief. He has chosen a large editorial board composed predominantly of Cleveland men to help with this task. A large part of the editorial work is being done in the library building.

The arrival of the Cleveland Branch of the Army Medical Library in June, 1941, was an event of great portent. It is certain that no one then fully appreciated how pleasant, how satisfactory, and how truly important an influence it would prove to be to the scientific and cultural life of Cleveland and the Cleveland Medical Library.

At a public meeting held in our auditorium the afternoon of November 6, 1944, salutations were offered to the Cleveland Medical Library on the occasion of her fiftieth birthday by the Presidents of neighboring institutions, Dr. William E. Wickenden of the Case School of Applied Sciences, Dr. Winfred G. Leutner of Western Reserve University, and Dr. Abram B. Bruner of the Academy of Medicine of Cleveland. The principal address of the afternoon was delivered by Dr. Normand L. Hoerr, Henry Willson Payne Professor of Anatomy, entitled "The Forgotten Man". It was an effective plea for more sympathetic and understanding consideration for the medical student than he has usually enjoyed. When the speaking was over, the members and guests had an opportunity to visit the library and examine the books. The following evening nearly 300 members and guests attended a banquet. Dr. William

H. Bruner, one of the charter members, gave a brief résumé of the library's history. Colonel Jones gave the principal address. Congratulations were offered by Dr. Henry Viets, Librarian of the Boston Medical Library; Dr. John F. Fulton, Chairman of the Library Committee of Yale University, and Dr. Wilburt C. Davison, Dean of the School of Medicine of Duke University.

Substantial gifts received in honor of this Jubilee Celebration from members and friends were allocated to general endowment funds, to the Dittrick Museum of Cultural Medicine, and to the purchase of old books.

In a library of the size and wealth of ours, there are both time and treasure to provide historical items of the remote past but only after the current needs have been well supplied. Modern texts, monographs and journals take precedence. The every day needs of the medical and dental students, the practicing physicians, the specialist consultant, the medical teacher and investigator, the medical author, historian and lexicographer must be met whether they be members of the medical, dental or veterinary medical profession.

The adequacy of our journal collections was tested by tabulating every reference appearing in 1941 in *The Journal of the American Medical Association*, *The Journal of the American Dental Association* and *The Journal of the American Veterinary Medical Association*. These journals were chosen because they seemed to be the largest, the most popular and the most generally available in each field. *The Journal of the American Medical Association* carried reference to 442 different periodicals, of which our library had 349 or 79 per cent, but of the 5,509 total references we had 5,350 or 97 per cent. *The Journal of the American Dental Association* carried references to 165 journals of which we had 133 or 80 per cent, and of 912 total references we had 833 or 91 per cent. *The Journal of the American Veterinary Medical Association* mentioned 57 journals of which we had 37, or 65 per cent, and of 259 total references we could supply 130, or 54 per cent. These figures indicate that the collection has been satisfactorily selected and that coverage especially in medicine and dentistry is satisfactory.

From the very beginning the Trustees have recognized the desirability of collecting and providing books and journals of historical interest. In fact the very first item provided for the library, if we except the file of *The Lancet* mentioned above, is the copy of Vesalius's *De humani corporis fabrica*, 1555. This was given by Dr. Howard A. Kelly as a nucleus of the old book collection at a meeting held in 1893, a year before the incorporation. Dr. Kelly had been invited to come from Baltimore to address the Cuyahoga Medical Society about the formation of a library.



The historical collection has continued to grow slowly.

In 1944 the most important acquisition was the completion of the file of the *Philosophical Transactions of the Royal Society of London*. This is the earliest scientific journal in the world save one which preceded it by 3 months and survived but 10 years. Publication started in 1665, and the journal continued despite the Great Plague and the Fire of London. It is indeed unfortunate that the many interesting items in the historical collection of the library are not better known, and the Director of the Library regrets that he can not personally demonstrate the collection to every member. The material is of little value unless it is recognized, appreciated and utilized.

The first obligation of the library is to care for the needs of the practising doctor, the interns, and the medical and dental students. These are the men who need the services most, being less able to provide for their necessities independently. The alert librarian senses their needs, anticipates their requirements and explores the possibilities for greater aid. Upon his ability to recognize such opportunities depend the librarian's and the library's success. The usefulness and availability of the library's resources are greatly enhanced by the free delivery system. The Cleveland Medical Library pays transportation charges on any item sent upon request to its members. Experience proves that this service has increased the usefulness of the library to many members at a cost which is not unreasonable.

*The News Letter* is another effort to improve the usefulness of the library and bring it closer to the members. This is an informal, irregularly appearing, anonymously written, mimeographed letter of several pages which endeavors to give information about acquisitions, notices, and exhibits, to make suggestions for vacation reading, to give explanations of policies or plans and to afford stimulation of discussions. It reminds the member that he belongs to a medical library, that the medical library is alive and alert and that its officers and administrators are constantly seeking to be more friendly, more sympathetic and more effective in bringing medical literature to him.

The attention of doctors of Ohio, who do not have adequate or convenient medical library service, is directed to the rules of the Cleveland Medical Library Association which provide for non-resident membership. This is available to any man living outside of Cuyahoga County who would otherwise be eligible to Associate Fellowship and includes reputable doctors of medicine, dentistry, or veterinary medicine. The delivery system free to members employing mail or express service is particularly useful to non-resi-

dent members who can not visit the library conveniently.

An examination of the finances of the Cleveland Medical Library demonstrates clearly that members get more than their money's worth from their annual payments to the Association. Only 15 per cent of current income is derived from membership dues. The members are the fortunate beneficiaries of fifty years of thoughtful planning, gracious giving and careful husbandry. The land was donated by Western Reserve University, the building was provided by gracious gifts, a substantial part of which came from non-medical friends. The Association is free of taxes. About one-half of the Association's income is derived from the investment of endowment funds.

Care must be exercised that income from other sources never overwhelms the importance of membership dues. Membership dues represent the weight and impact, the effect and influence, the needs and requirements of the doctors of today, the living, active, changing, evolving and adapting professional influence. Should this be submerged, it is conceivable, although by no means inevitable, that management of the library, through self-perpetuating boards, might become aloof from current needs and practices. An active, aggressive, alert, and informed membership is the best insurance we have against bureaucracy. There is nothing the library needs which can not be obtained, given imagination enough to recognize it, time enough to outgrow certain war time restrictions and the will of the members translated into effective action by inspired leadership.

The Cleveland Medical Library is a free and independent association, a corporation not for profit, without entangling alliances or obligations, owing no man or organization. The ownership and management rest ultimately with the members. The members have the right and the responsibility of determining and directing the manner in which the library is run, a right they exercise by the election of Trustees who carry out the members' bidding, report their actions periodically, and serve to the members' satisfaction. The Trustees have an obligation to fulfill the expressed desires of the members and of the donors of the past and to return to the community in service what they wished to provide with their wealth.

The administration of this great library is a serious public trust. Such an accumulation of the world's recorded experience, available today very largely because of the generosity and provident foresight of a former generation, must be offered for study to all who are competent to profit from association with it. Restrictions in its use are only those which seem proper for reasonable protection and eventual preservation.

# Review of Action Taken by Ninety-Sixth Ohio General Assembly on Medical, Health and Welfare Proposals

**T**HE longest session of the Ohio General Assembly in recent years came to an end officially on July 19. Of the 832 bills considered, the Ninety-Sixth General Assembly enacted a total of 214, two of which were re-enacted over the veto of Governor Lausche.

Approximately 50 of the measures considered by the General Assembly related to medical or health activities. A number of proposals of definite value to public health, especially in the field of mental hygiene, were enacted.

No bills detrimental to public health and medical standards in Ohio were passed. This was due primarily to the fine work done in most of the counties by the legislative committeemen of the county medical societies in acquainting their representatives and senators with the dangers and fallacies of certain pending measures.

Nevertheless, an alarming amount of support was accorded several dangerous proposals which were defeated only after hard fights in committee or on the floor of the Assembly. This proves again that the first line of defense against harmful health legislation is at the voting booths where ballots are cast for candidates to the Legislature.

On the whole, however, the Assembly was conservative and in the final analysis took no action which can be construed as detrimental to medical and health standards.

Following is a digest of action of the General Assembly on health and medical proposals:

## Efforts to Lower Medical Standards Defeated

Three measures, which would have lowered medical standards and harmed public health in Ohio by permitting incompetent persons to engage in the practice of medicine or by granting certain limited practitioners rights and privileges in excess of their education and training, were defeated.

House Bill 62 (similar to Senate Bill 164), which would have permitted Christian Science practitioners to engage in the practice of healing without legal restrictions or having to meet any educational qualifications, was defeated twice on the floor of the House. On the first vote, the proposal lacked 10 votes of the 69 votes required to pass a bill. A month later the vote by which the bill failed was reconsidered and the proposal was voted on again. This time it failed by nine votes. Terrific pressure was exerted by the Christian Science lobby and by a bloc of legislators, primarily from some of the larger cities, for this bad bill. The heated debates on this proposal on the floor of the House lasted from three to four hours on each occasion. Despite desperate jockeying and log-rolling, the proponents were unable to get Senate Bill 164 out of the Senate Judiciary Committee although efforts to do so were made even after House Bill 62 had been defeated on the floor of the House.

House Bill 284, to create a separate examining and licensing board for chiropractors and to

greatly increased the rights of chiropractors failed to get enough votes in the House Welfare Committee and died in that committee. Nevertheless, the vote was close (in fact, only one additional vote was needed) and the final outcome was much in doubt up to the time the votes were counted.

House Bill 224, to require the State Medical Board to license naturopaths on examination or by waiver (primarily by waiver), was tabled by the House Health Committee. If enacted, this bill would have opened wide the gates to a large number of inferior practitioners of other states—in fact anyone holding a degree of "Doctor of Naturopathy" obtained after a course of several months in a chiropractic school or by taking a correspondence school course in naturopathy—whatever that may be.

## Prenatal Examination Bill Gets Favorable Vote

Among the measures relating directly to public health activities which were enacted, the prenatal examination proposal is perhaps the most important.

Senate Bill 90, which will become effective August 22, 1945, provides that a physician or other person authorized by law to attend a pregnant woman shall take or cause to be taken within 10 days of the time of the first examination of the woman a specimen of blood for a serologic test for syphilis. The laboratory ex-



amination must be made in a laboratory approved by the Ohio Department of Health. In reporting the birth, the physician or other person must indicate whether the serologic test for syphilis was made in an approved laboratory and the approximate date when the specimen was taken.

If the test was not made, the reason or reasons why the test was not made shall be stated. The result of the test is not to be reported by the physician but the laboratory making the test is required to send the original report to the physician submitting the specimen and a duplicate to the Ohio Department of Health.

If in the opinion of the attending physician the condition of the pregnant woman does not permit the taking of a blood sample, he is not required to take the blood specimen prior to delivery but is expected to take the specimen for submission to a laboratory as soon after delivery as he deems advisable. If the woman refuses to submit to the taking of blood specimen, the physician need not take such sample and may state on the birth report that the patient's refusal is the reason why the test was not made.

In the event the woman is attended by a person not authorized by law to take blood samples, the person in attendance must request the health commissioner of the city or general health district to take the specimen and to submit it to an approved laboratory. If the patient is unable to pay for the serologic test, the specimen may be submitted to the Ohio Department of Health Laboratory.

Wilful violation of the provisions of the act is punishable by a fine of not less than \$20.00 nor more than \$100.00 and the costs of prosecution. If the offender fails to pay the fine and costs, he may be imprisoned not less than 10 days nor more than 30 days.

Laboratories approved for the making of serologic tests as a part of the premarital examinations required by Ohio law will be recognized by the Ohio Department of Health as approved for tests required by the prenatal examination law.

### **Other Measures Relating to Public Health Activities**

Following are brief analyses of other bills directly relating to public health activities, some of which were enacted and some of which failed to receive favorable action:

House Bill 249, to authorize the Ohio Department of Health to devise a suitable program for establishing a blood bank for civilian use, was enacted and will become effective October 12. The proposal specifies that the program may embrace methods for registration of blood donors, for the collection of blood, for the processing or procurement of blood plasma or

other substitutes for whole blood and for the distribution of pooled blood, blood plasma or other blood substitutes to communities where there is a need for such materials. It authorizes the department to establish standards and rules and regulations for carrying out such program to utilize the facilities and services of other official agencies and voluntary organizations engaged in a similar program.

House Bill 31, to enlarge the Ohio Public Health Council by one member who shall be a registered pharmacist, was passed early in the session and became effective May 30.

**Time and space will not permit a complete analysis of some of the laws enacted by the recent Ohio General Assembly, but The Journal from time to time will publish detailed reviews of some of the measures listed in the accompanying article, especially those relating to mental hygiene activities and to the care of children.**

House Bill 374, to improve the state program for control and elimination of Bang's disease in cattle, was enacted, with subsidy of approximately \$1,000,000 provided for financing the program. Effective September 10.

Senate Bill 345, to create a commission for the study of slum clearance, enacted and effective October 12.

House Bill 434, to strengthen the law relating to the pollution of streams and the protection of public water supplies, enacted and effective October 11.

Senate Bill 19, to create a commission to study the needs for an improved tuberculosis program in Ohio; Senate Bill 257, to appropriate \$40,000 for a tuberculosis control program under the Ohio Department of Health, and Senate Bill 106, to provide subsidies for the operation of county and district tuberculosis hospitals, were not enacted.

House Bill 16, to change the time for meeting of Advisory Council of a general health district, from February to March and to provide for a \$5.00 per diem and expenses in attending such meeting, was enacted and becomes effective July 20.

Additional health bills which failed to pass were: Senate Bill 147, to transfer the inspection and licensing of hotels and restaurants from the State Fire Marshall's Office to the Ohio Department of Health; Senate Bill 184, relative to keeping places where food is sold, manufactured

or stored in a sanitary condition; **Senate Bill 228**, to create a Cancer Study Commission; **Senate Bill 261**, to make the fortification of bread with vitamins mandatory; **Senate Bill 273**, to prescribe the ingredients of bread; **Senate Bill 308**, and **House Bill 189**, to require the vaccination of dogs against rabies.

### **Laws to Improve and Enlarge Ohio Mental Hygiene Program**

A number of important measures dealing with mental hygiene activities were considered. Most of these were sponsored by the Governor's Committee on a Mental Health Program for Ohio.

Improvements in Ohio's Mental Hygiene Program will result from the passage of a series of bills modernizing administrative procedure and from passage of **House Bill 477**, known as the "Additions and Betterments Bill", appropriating approximately \$17,000,000 from the state's surplus for capital improvements at various state institutions for the mentally ill, mentally deficient and epileptic.

Unfortunately, a reduction was made in the amount requested by the Division of Mental Hygiene for educational work but funds may be obtained for this activity at a later date by special appeal to the Board of Control. Funds totaling \$25,000,000 for Welfare Department operating expenses were appropriated in **House Bill 484**, the general Appropriations Bill an all-time record.

Following is a digest of the more important proposals relating to administrative procedures for the care of the insane, feeble-minded, epileptic and psychopathic:

**Senate Bill 48**, changing the name of the Division of Mental Diseases to Division of Mental Hygiene and to facilitate transfer of institutionalized persons who are mentally ill, mentally deficient or psychopathic from one institution to another, was enacted and will be effective October 11.

**Senate Bill 87**, to provide for indefinite commitment of mentally ill, mentally deficient and psychopathic; to require the State Welfare Department to provide or designate special institutions for the custody and care of mentally deficient, insane or psychopathic criminals and offenders, and to modernize the procedures for the commitment, transfer and discharge of such persons, was passed and will become effective October 11.

**Senate Bill 137**, to provide for use of the Mt. Vernon Tuberculosis Sanitarium exclusively for the care and treatment of mentally ill, mentally deficient and epileptic persons suffering from tuberculosis, was enacted. Effective September 28.

**Senate Bill 346**, to appropriate \$1,190,000 for new buildings and equipment at the Mt. Vernon

institution, referred to above, was passed as an emergency measure and became effective July 10.

**Senate Bill 212**, to provide suitable means for one adjudged mentally ill, feeble-minded or epileptic to procure an adjudication of competency. Enacted and effective October 8.

Several other measures introduced independently were not enacted but their chief provisions inserted as a part of **Senate Bills 48 and 87**.

Interpretative articles on the provisions of the bills listed above will be published in a later issue of *The Journal*.

### **Fund of \$5,000,000 Provided for Medical and Dental Colleges**

One item of special interest to the medical profession in the "Additions and Betterments Bill", **House Bill 477**, which was enacted, is an appropriation of \$5,000,000 for improvements in and expansion of the facilities of the College of Medicine and College of Dentistry, Ohio State University, and construction of a new hospital for clinic teaching and research.

### **Measures on Care of Handicapped and Underprivileged Children**

The Ninety-Sixth General Assembly enacted a number of constructive proposals relating to the adoption, juvenile court procedures, and the care and education of handicapped and underprivileged children, most of them sponsored by the Children's Code Commission. Action taken on bills in this classification follows:

**Senate Bill 46**, which revises the statutes on the care of crippled children, was enacted and becomes effective October 11. Under the new law, the age limit for the acceptance of crippled children for care and treatment is increased from 18 to 21 years; if a crippled child does not have a legal settlement in the county or state the cost of necessary care until legal settlement is obtained can be paid from Federal funds allocated to Ohio for the care of crippled children; the State Division of Social Administration may arrange for the care and treatment of crippled children committed to it by the juvenile court on its own initiative or on application of parents or guardians, the expenses to be paid by the state division but charged back to the county from which the child is committed; money paid by parents or guardians for care of crippled children committed to the state division shall be payable to the state division and distributed by it for the use of the county from which a child is committed.

**Senate Bill 65**, which provides for special classes and educational services for physically and mentally handicapped children in local school districts with the consent of the state superin-



tendent of public instruction, was passed and becomes effective October 16. The superintendent of public instruction may prescribe standards. An amount of \$850,000 for 1945-46 was appropriated to be used to reimburse local school districts for expenses involved in conducting such special classes.

**Senate Bill 66**, to provide that schools conducting medical and health programs shall provide hearing and visual tests for pupils under the supervision of the Ohio Department of Health, failed as it was not placed on the calendar by the House Rules Committee before adjournment.

**Senate Bill 186**, which makes improvements in the procedure for adoption and placement of children, was enacted and becomes effective October 11.

**Senate Bill 209**, provides that a board of education may establish special instruction for children afflicted with tuberculosis, may use school funds for such purposes, and shall be entitled to receive state moneys authorized for the attendance of pupils under the school foundation program, for tuition costs, and for additional compensation as is provided for crippled children. It was enacted and becomes effective September 21.

**House Bill 385**, clarifies the law regarding legal settlement of a minor. It was passed and becomes effective October 11 and provides that the legal settlement of a minor shall be that of parents or guardian, except that a minor female who marries shall have the legal settlement of her husband; that a male minor who marries shall have legal settlement in the county in which he has resided continuously for at least one year; and that a male or female minor who is 18 years of age or over, who is emancipated and has resided and supported himself or herself in any county for at least two years, shall have legal settlement in such county. Also, the law provides that legal settlements obtained as above shall be without regard to the county of legal settlement of the parents or guardian and that no person may establish a legal settlement in Ohio for the purpose of gaining admission to any state institution.

**House Bill 418**, recodifies the laws relating to the county care of dependent, neglected, delinquent and handicapped children and provides for unification of county services for children. This bill passed and becomes a law October 11, but does not take effect until January 1, 1946.

**House Bill 463**, recodifies and clarifies the laws relating to the activities of the juvenile courts, the statutes relating to marriage consent, and statutes relating to offenses against children. It was enacted and becomes a law

October 11 but does not take effect until January 1, 1946.

**House Bill 142**, to provide for a pension survey commission to make a study of all governmental pension programs, including the old age pension program, was enacted and becomes effective October 17.

A large number of bills on welfare activities, poor relief and old age pensions were not passed. Among them were the following: **Senate Bill 283**, to establish a child welfare study commission; **Senate Bill 287**, to increase the limitation on poor relief administrative expenses; **Senate Bill 57**, to create a State Bureau for the Physically Handicapped; **House Bill 175**, to increase old age pensions and to provide for payment of medical expenses, in addition to a pension, up to \$200.00 in any one year; **House Bill 304**, to reorganize the Commission for the Blind; **House Bill 367**, to limit to \$10.00 the amount a township must pay for medical or hospital care for an indigent; **Senate Bill 183**, to include hospitalization in the definition of poor relief as used in the State Relief Act and provide for payment of hospitals under the provisions of the State Relief Act; **House Bill 324**, to permit the transfer of pregnant women committed to any state institution to a licensed maternity hospital at time of delivery.

### Laws Relating to Duties of County Coroner Are Recodified

By enacting **Senate Bill 92**, the Legislature modernized, clarified and strengthened the laws relating to the duties of the county coroner. The new law becomes effective October 12.

**Senate Bill 92**, as enacted, contained the following provisions:

To be eligible to the office of coroner a person must be a physician who has been licensed in Ohio for a period of at least two years immediately prior to his election or appointment and who is in good standing in his profession, or a person who is serving as coroner at the effective date of this act. There are at present only three or four persons who are not physicians now serving as county coroner.

When the office of coroner becomes vacant or the coroner becomes permanently unable to perform the duties of the office, the county commissioners shall appoint a qualified person as coroner. When the coroner is temporarily absent, in the armed forces, or temporarily unable to perform the duties of the office, the coroner may appoint a person with the qualifications for the office as acting coroner to serve until the coroner can resume his duties.

The office of coroner is placed on an annual salary basis and the old system of compensating coroners on a fee basis is abolished. In counties of less than 25,000 population, the annual salary

shall be \$400 and the coroner shall receive additional compensation as follows: one and one-half cents per capita for the population of the county in excess of 25,000 and not in excess of 200,000 and one cent per capita for the population of the county in excess of 200,000. The annual compensation shall not exceed \$6,000 in any county.

Duties of the coroner are expanded and strengthened by providing that when any person shall die as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent good health, or in any suspicious or unusual manner, the physician called in attendance or any person finding the body or acquiring first knowledge of any such death, shall immediately notify the office of the coroner and submit any information in his possession which may be requested by the coroner. In such cases, if a request for cremation is made, the funeral director called in attendance, shall notify the coroner immediately.

The coroner, or his deputy, if he deems it necessary, shall take charge of the body and may authorize an autopsy. The coroner may conduct an inquiry, subpoena witnesses, etc., and shall make a report to the county prosecutor. The prosecutor may order a body disinterred for examination. The coroner may take possession of personal effects of the deceased found in connection with the body. He shall notify relatives and if relatives are unknown he shall advise the fact of the death in a newspaper. Personal effects of the deceased may be sold by the coroner if the body is unclaimed and buried at the expense of the county.

Any person who shall wilfully refuse to report such a death or who without an order from the coroner shall wilfully touch, remove, or disturb the body or any clothing or article upon or near the body, shall be guilty of a misdemeanor and if convicted shall be fined not less than \$100 nor more than \$500.

The coroner may hold or order a body held until such time as he, after consultation with the county prosecutor or police or sheriff, has reached a decision that it is not necessary to hold the body longer for the purposes of examination or to assist such officials in their investigation of the case.

The provisions of Section 9984 of the General Code providing that unclaimed bodies shall be turned over to medical schools for purposes of scientific research are not disturbed by the new law which specifically states that this shall be done by the coroner.

The law permits the establishment of suitable offices, laboratories and equipment in the county for the use of the coroner; provides that the coroner may appoint assistant coroners, one of whom shall be designated chief deputy coroner, pathologists, and other personnel to assist him

in his work and to fix their salaries but the compensation shall not exceed in the aggregate the amount fixed by the county commissioners for the office of coroner; and specifies what records shall be kept by the coroner and how they shall be kept. It provides that coroners' laboratories may perform examinations for coroners in counties having no such laboratory and that fees collected for such work shall be paid into a special fund to be used to buy necessary supplies and equipment for the laboratory.

All present sections relating to the duties of the coroner which are in conflict with the provisions of the new law or the provisions of which are covered by the new law are repealed.

### **Provisions of the Ohio Workmen's Compensation Law Liberalized**

Senate Bill 211, the Workmen's Compensation Bill, having the support of industry and labor, was enacted and becomes effective October 12. A dozen or more independent measures to amend the Workmen's Compensation Law were not passed. The chief provisions of Senate Bill 211 are as follows:

Increases the salaries of members of the Industrial Commission to \$6,500.

Provides that compensation for total disability or death from silicosis shall be payable only in event disability or death resulted within eight years instead of two years, after the last injurious exposure and that the requirement of death within two years after the last injurious exposure shall not apply in event the death followed continuous total disability commencing within eight years, instead of two years, after the last injurious exposure.

Increases until September 30, 1947, the maximum weekly compensation for temporary total disability, temporary and permanent partial disability and permanent total disability and for death from \$21 to \$24.50 but only for injuries and diseases occurring after this act takes effect.

Increases until September 30, 1947, the weekly minimum compensation for temporary and permanent total disability from \$8 to \$10 but only for injuries and diseases occurring after this act takes effect.

Permanently increases the maximum death award from \$7,000 to \$7,500.

Payments for losses of members are continued at a maximum of \$24.50 a week for the number of weeks prescribed by the schedule whether or not such number of weeks carries the payments beyond September 30, 1947.

### **Miscellaneous Proposals of Special Interest**

Following is a report of action on a number of miscellaneous measures of special interest to physicians:



Senate Bill 163, liberalizing the Unemployment Compensation Act to provide for a maximum compensation of \$21 per week, disqualifying a person who leaves work voluntarily without just cause, reducing to \$160 the amount of qualifying wages, and providing certain clarifying provisions, was enacted and becomes effective October 12.

House Bill 69, abolishing the State Council of Civilian Defense, was passed and takes effect October 8.

Senate Bill 317, to designate the Ohio Department of Health as the official state agency to cooperate with the Federal Government in making a survey of hospital needs and to handle Federal funds allocated to Ohio for that purpose and for building hospitals, got lost in the shuffle at the wind-up.

House Bill 92, to improve the laws regulating drug stores and requiring that certain preparations must be sold only in a drug store in charge

of a registered pharmacist, was enacted and becomes effective October 16.

Senate Bill 44, requiring additional state departments, boards and commissions to submit to the provisions of the Administrative Practice Act, was passed and takes effect October 12.

Senate Bill 56, tightens up the laws relating to fraudulent advertising and permits the prosecuting attorney to bring permanent injunction proceedings against repeated offenders. It will take effect October 12.

Senate Bill 157, to clarify the definition of a hospital in the Hospital Service Plans Enabling Act and the agreements between Hospital Service Associations and non-participating hospitals, was enacted and will become effective September 4.

Senate Bill 169, to increase the salaries of county elected officials, Senate Bill 60 to increase the salaries of state elected officials and House Bill 121 to increase the salaries of state appointed officials, all failed to pass.

## Stock of Ohio Medical Indemnity, Inc., Selling at Lively Rate; Over-subscription of Issue is Anticipated

AS this issue of The Journal went to press, subscriptions for preferred stock of Ohio Medical Indemnity, Inc., were being received at a lively rate at the temporary offices of the company—1005 Hartman Theater Building, Columbus 15, Ohio.

Approximately 1,700 of the 2,000 shares offered for sale to Ohio physicians had been purchased up to press time. As the deadline for the close of the books for the sale of stock is set for August 4, the incorporators were confident that the issue would be fully subscribed by that date.

Assuming that all the preferred stock will have been purchased and the money paid in by August 4, the executive committee handling details with respect to organization of the company and qualifying it under State Insurance Laws will devote the next several weeks to perfecting the contract, benefit schedule and schedule of rates and to carrying on negotiations with the Superintendent of Insurance. It is hoped that the company will be ready to start business on September 1 or shortly thereafter.

The incorporators were particularly impressed with the excellent response from doctors in all parts of the state on the matter of subscriptions and with the interest shown by many physicians now in military service, quite a number of whom have purchased stock.

# A.M.A. Board Adopts Constructive 14-Point Program for Extension of Improved Health and Medical Care for All

A 14-point platform setting forth recommendations for the extension of improved health and medical care for people in all communities and in all economic categories has been adopted by the Board of Trustees of the American Medical Association, on recommendations of the Council on Medical Service and Public Relations of the A.M.A.

Text of this program—a constructive program in contrast to the plan which would be established by the Wagner-Murray-Dingell Bill, S. 1050, now pending before Congress—follows. It should be studied by all physicians and especially by officers and proper committees of county medical societies as many of the recommendations will require initiative and action on the part of local medical societies:

## PREAMBLE

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of human-kind. Science, as history well demonstrates, prospers best when free and unshackled.

## PROGRAM

The physicians represented by the American Medical Association proposed the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of Federal legislation to provide for adjustments in draft regulation which



will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular Army, Navy and United States Public Health Service.

#### EDITORIAL COMMENT

Commenting on the program in its July 21 issue, *The Journal of the A.M.A.* said editorially:

"By this program the American Medical Association supports improvement in nutrition, housing and living conditions that are fundamental to good health. Again it places the American Medical Association behind the extension of qualified public health and preventive medical service. The program recognized that plans for insurance against the costs of hospitalization on a voluntary basis have now been sufficiently developed to warrant support, although some controversial questions have not yet been satisfactorily settled. The care of the indigent, for which there are no suitable provisions under existing or proposed national or other compulsory sickness insurance plans, may by new technics be incorporated into voluntary sickness insurance plans.

"Fundamental to a scientific plan for meeting needs for medical care is the scientific survey which determines the existence and scope of such needs. This fact is recognized in the proposals that surveys be made to determine these needs and that Federal aid be given where needs are demonstrated, with the understanding that administration and control will be under local auspices.

"The final measures in this program relate to problems associated with the war and the situations created by military service. More than 60,000 physicians have been involved in military and other government services, while less than 90,000 physicians have tried to meet the needs of the civilian population. On these physicians has rested a great burden. Every one now agrees that discharge of physicians from the armed services as rapidly as possible is necessary for the maintenance of medical care. . . .

"The needs of medical education have been told repeatedly and are again emphasized in this constructive program. Unless plans provide for a sufficient number of young men and women in the premedical curriculum, the nation will face a desperate shortage of physicians in the coming years. . . .

Dr. William W. Richardson, co-owner and medical director of the Mercer Sanitarium, Mercer, Pa., died June 22, aged 68. He was assistant physician of the Columbus State Hospital from 1903 to 1906.

### Health Service Officers Given Same Status as Those of Military

Effective July 29 for the duration of the war, the commissioned corps of the United States Public Health Service became a branch of the land and naval forces of the United States under an executive order signed by President Truman on June 21.

Administration of the Public Health Service is not affected by the executive order. The service continues to operate as a part of the Federal Security Agency. Public Health Service officers will be subject to the Articles for the Government of the Navy, with authority conferred by the Articles and by law on the Secretary of the Navy and the Commander of a fleet vested in the Federal Security Administrator and the Surgeon General of the Public Health Service.

Under the executive order, commissioned officers of the service will be subject to the same discipline and obligations and will have the same status as members of the Army, the Navy and the Coast Guard. Their postwar status will be the same as all other veterans.

The order also establishes uniformity in discipline and benefits among Public Health Service commissioned personnel. Up to the present, commissioned officers detailed to the Army, Navy, and Coast Guard, and all officers serving overseas have received full military benefits under the Public Health Service Act of 1944. The remainder of the corps has been entitled to only limited benefits.

There are now 3,175 commissioned officers in the U.S. Public Health Service, including physicians, dentists, sanitary engineers, pharmacists, scientists and nurses. The Public Health Service operates the medical services of the Coast Guard. Practically all members of the corps are assigned to duties which have arisen directly out of the war effort.

Speakers at a conference for rural county leaders on Medical Care, Health Services and Facilities, held at Ohio State University, July 19-20, included: Dr. Carll S. Mundy, Toledo, member, Ohio Rural Health Committee; Dr. Roger Heering, Columbus, State Director of Health; Dr. Frank F. Tallman, Columbus, State Commissioner of Mental Diseases; Dr. Harry Wain, Troy, health commissioner of Miami County, and Charles S. Nelson, Columbus, executive secretary, Ohio State Medical Association.

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A Columbus physician, Dr. Guilford B. Hoiston, is the new president of the Ohio Negro Chamber of Commerce. He returned recently to private practice after four years in the Army Medical Corps, retiring with the rank of captain.

# Morbidity Reports Section of Ohio Sanitary Code Revised By Public Health Council; Changes Effective August 1

**E**FFECTIVE August 1, Ohio physicians must report cases of rheumatic fever to local public health authorities, in accordance with an amendment to the Ohio Sanitary Code adopted by the Ohio Public Health Council at a meeting in Columbus, June 24. This action was recommended in a resolution approved by the House of Delegates of the Ohio State Medical Association at the 98th Annual Meeting in Columbus, May 2-4, 1944.

The Public Health Council also made a change in the isolation period for scarlet fever. Previously 21 days, isolation for scarlet fever now can be terminated when the attending physician has determined from the clinical course of the disease that the period of communicability is over.

In view of the importance of accurate vital statistics in planning for the protection of public health, *The Journal* presents herewith the Morbidity Reports Section of the Ohio Sanitary Code, as amended June 24.

**Regulation 2. (Diseases, disabilities and infestations to be reported.)** The diseases, disabilities and infestations herein named and classified as "Class A" and "Class B" are declared to be dangerous to the public health, are made notifiable, and the occurrence of cases or suspected cases in Ohio shall be reported as provided in the following regulations. The diseases, disabilities and infestations herein named and classified as "Class C" are only required to be reported when they occur in unusual prevalence in a health district.

## CLASS A

|                              |                               |
|------------------------------|-------------------------------|
| Actinomycosis                | Measles (rubeola)             |
| Anthrax                      | Meningococcus meningitis      |
| Botulism                     | (cerebro-spinal fever)        |
| Chickenpox (varicella)       | Milk sickness                 |
| Chancroid                    | Mumps (infectious parotitis)  |
| Cholera                      | Paratyphoid fever             |
| Dengue                       | Pellagra                      |
| Diphtheria                   | Plague, bubonic, septicemic,  |
| Dysentery, Amebic            | pneumonic                     |
| (Amebiasis)                  | Pneumonia, acute lobar        |
| Dysentery, bacillary         | Polioomyelitis                |
| Encephalitis infectious (le- | Psittacosis                   |
| thargic and non-lethargic)   | Puerperal infection (puer-    |
| Epidemic diarrhea of the     | peral septicemia)             |
| newborn                      | Rabies (in man)               |
| Erysipelas                   | Rheumatic fever               |
| Favus                        | Rocky Mountain (spotted (or   |
| Food infections and poison-  | tick fever)                   |
| ings                         | Scarlet fever (scarlatina)    |
| Foot and mouth disease (in   | Septic sore throat            |
| man)                         | Smallpox (variola)            |
| German measles (rubella)     | Syphilis                      |
| Glanders                     | Tetanus                       |
| Gonorrhea                    | Trachoma                      |
| Gonorrheal ophthalmia        | Trichinosis                   |
| Hookworm disease (ancylos-   | Tuberculosis, pulmonary       |
| tomiasis)                    | Tuberculosis, other than pul- |
| Inflammation of the eyes of  | monary                        |
| newborn (Ophthalmia neo-     | Tularemia                     |
| natorum)                     | Typhoid fever                 |
| Influenza                    | Typhus fever                  |
| Leprosy                      | Undulant fever (brucellosis)  |
| Lymphogranuloma venereum,    | Whooping cough (pertussis)    |
| granuloma inguinale, and     | Yaws (frambesia)              |
| climatic bubo                | Yellow fever                  |
| Malaria                      |                               |

## CLASS B Occupational Diseases (G.C. 1243-1)

|                            |                          |
|----------------------------|--------------------------|
| Aniline poisoning          | Dinitrobenzene poisoning |
| Arsenic poisoning          | Lead poisoning           |
| Benzene (gasoline) poison- | Mercury poisoning        |
| ing)                       | Naphtha poisoning        |
| Benzol poisoning           | Natural gas poisoning    |
| Brass poisoning            | Phosphorus poisoning     |
| Carbon monoxide poisoning  | Turpentine poisoning     |
| Compressed-air illness     | Wood alcohol poisoning   |

## CLASS C

|                         |                              |
|-------------------------|------------------------------|
| Ascariasis              | Hemorrhagic jaundice (spiro- |
| Coccidioidomycosis      | chetosis icterohemorrhagic,  |
| Common cold             | Weil's disease)              |
| Filariasis              | Impetigo contagiosa          |
| Pediculosis (lousiness) | Schistosomiasis              |
| Rat-bite fever (sodoku) | Vincent's infection (Vin-    |
| Relapsing fever         | cent's angina, ulcerative    |
| Ringworm (dermatophy-   | or necrotic stomatitis       |
| tosis)                  | trench mouth)                |
| Scabies (the itch)      |                              |

Adopted May 14, 1920; amended June 24, 1945; effective August 1, 1945.

**Regulation 16. (Methods of control.)** These methods of control shall be enforced by all local health officials in the state of Ohio and shall be observed by any person afflicted with any of the following named diseases or conditions and by their attendants and associates. The definition of terms found in Regulation 11, Ohio Sanitary Code, shall apply when such terms are used in this regulation:

## CLASS A

### Regulation 16-33. (Rheumatic fever.)

#### A. The infected individual, contacts, and environment:

1. Recognition of the disease and reporting: On the basis of clinical examination.
2. Isolation: None.
3. Concurrent disinfection: None.
4. Terminal disinfection: None.
5. Quarantine: None.
6. Immunization: None.
7. Investigation of source of infection: None.
8. Prophylaxis: Individuals who are known to have had prior attacks of rheumatic fever and who are free from active disease are less likely to develop streptococcal throat infections during the winter and spring months if treated during this time of year with a recognized chemotherapeutic agent (such as the sulfonamides) administered under continuing medical supervision in the appropriate prophylactic dosage. Sulfonamide prophylaxis is ineffective following the onset of a streptococcal infection and is contraindicated for the active case of rheumatic fever.

#### B. General Measures:

1. Careful medical examination of children with vague symptoms, e.g., malaise, pallor, failure to gain weight, epistaxis and transient aches and pains; appropriate laboratory tests should be included.
2. Emphasis on the fact that rheumatic ac-





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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



tivity may begin insidiously and may cause incapacitating heart disease.

Adopted June 24, 1945; effective August 1, 1945.

#### Regulation 16-35. Scarlet fever (scarlatina).

##### A. The infected individual, contacts, and environment: (Control of streptococcal infections depends on preventing the dissemination of hemolytic streptococci.)

1. Recognition of the disease and reporting: On the basis of clinical examination.
2. Isolation or segregation: Preferably in a single room, cubicle or small ward. This period, whether in the home or hospital, should be determined on the basis of the clinical course of the infection. In uncomplicated cases the period of communicability should be completed within 14 days.
3. Concurrent disinfection: All objects which have been soiled by purulent discharges and all articles which have been in contact with the patient.
4. Terminal disinfection: Thorough cleaning of contaminated objects, scrubbing of floors and sunning of blankets to prevent dissemination of infected particles.
5. Quarantine: As provided by state law.
6. Immunization: By active immunization a potential scarlet fever patient can be made Dick negative. This will not protect the individual against streptococcal infection.
7. Investigation of source of infection. Responsible authorities should determine whether an outbreak is caused by personal contact or by contaminated food or milk. Tracing outbreaks to an individual with a persistent streptococcal disease can often be accomplished by identification of the serologic type. Contaminated milk or food can often be determined by culture.

##### B. General Measures:

1. Provision for throat cultures with isolation of hemolytic streptococci and identification of the serologic groups.
2. Education in the danger from infection with hemolytic streptococci whether or not scarlet fever is manifest in the patient.
3. Pasteurization of milk supply.
4. Exclusion of infected persons from handling milk or milk products.
5. In the absence of an epidemic, the milk from any cow with evidence of mastitis should be excluded from sale or use as a protection in addition to pasteurization.
6. The majority of persons exposed to hemolytic streptococcal infection can be protected by the administration of a recognized chemotherapeutic agent (such as the sulfonamides) under medical supervision. This is not free from danger and does not obviate the necessity for appropriate personal precautions.
7. Observation for one week of persons exposed or potentially exposed.
8. Daily inspection of exposed children in school by nurse or physician.
9. Segregation of persons with evidence of

upper respiratory infection throughout the clinical course of their disease.

10. Prompt investigation of any group of cases as to possibly contaminated milk supply with exclusion of suspected milk supply from sale or use until pasteurized.

Adopted May 14, 1920; amended June 24, 1945; effective August 1, 1945.

#### Regulation 16-36. Septic Sore Throat (Streptococcal Sore Throat, Streptococcal Nasopharyngitis, Streptococcal Tonsillitis.)

##### A. The infected individual, contacts and environment: (Control of streptococcal infections depends on preventing the dissemination of hemolytic streptococci.)

1. Recognition of the disease and reporting: On the basis of clinical examination.
2. Isolation or segregation: Preferably in a single room, cubicle or small ward. This period, whether in the home or hospital, should be determined on the basis of the clinical course of the infection.
3. Concurrent disinfection: All objects which have been soiled by purulent discharges and all articles which have been in contact with the patient.
4. Terminal disinfection: Thorough cleaning of contaminated objects, scrubbing of floors and sunning of blankets to prevent dissemination of infected particles.
5. Quarantine: Not indicated.
6. Immunization: None.
7. Investigation of source of infection: Responsible authorities should determine whether an outbreak is caused by personal contact or by contaminated food or milk. Tracing outbreaks to an individual with a persistent streptococcal disease can often be accomplished by identification of the serologic type. Contaminated milk or food can often be determined by culture.

##### B. General Measures:

1. Provision for throat cultures with isolation of hemolytic streptococci and identification of the serologic groups.
2. Pasteurization of milk supply.
3. Exclusion of infected persons from handling milk or milk products.
4. In the absence of an epidemic, the milk from any cow with evidence of mastitis should be excluded from sale or use as a protection in addition to pasteurization.
5. The majority of persons exposed to hemolytic streptococcal infection can be protected by the administration of a recognized chemotherapeutic agent (such as the sulfonamides) under medical supervision. This is not free from danger and does not obviate the necessity for appropriate personal precautions.
6. Segregation of persons with evidence of upper respiratory infection throughout the clinical course of their disease.
7. Prompt investigation of any group of cases as to possibly contaminated milk supply with exclusion of suspected milk supply from sale or use until pasteurized.

Adopted May 14, 1920; amended June 24, 1945; effective August 1, 1945.



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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### A BOOKLET EVERY MEDICAL OFFICER SHOULD HAVE

A booklet, "Information for Medical Officers", has been issued by the Bureau of Information of the American Medical Association. It contains a description of the educational and loan provisions of the G. I. Bill of Rights, a review of educational facilities in civilian institutions, aids in establishing a practice, data on licensure and reciprocity between states, graduate courses, roster of specialty examining boards, etc.

This should be a handy source of information for medical officers. Ohio officers are urged to write to the Chicago office of the A.M.A. and request a copy.

Detailed information on these subjects can be furnished, if available, by the Bureau of Information or by the Columbus Office of the Ohio State Medical Association. If our Columbus office doesn't have the data to answer questions at once, it will attempt to get the answers.

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### COLUMBUS SETS UP UNIQUE LOAN PLAN FOR RETURNING DOCTORS

At the suggestion of Dr. George Heer, its president, and endorsed by its membership, the Columbus Academy of Medicine has established a Veterans' Collateral Pool Fund of \$50,000 for the purpose of "assisting, in a material yet uncompromising way, those returning veteran members of the Columbus Academy of Medicine, who may need financial assistance in establishing or re-establishing themselves in the practice of medicine".

The Columbus plan is unique. It has gone over with a bang. The details are summarized here for the benefit of other local medical societies or groups of physicians who may be thinking about starting a similar project.

Columbus physicians individually were requested to purchase one or more 1½ per cent U.S. Treasury Coupon Bonds, due in 1950, in the amount of \$500 each, and to sign an agreement, the pertinent provisions of which are:

That the bond is to be placed in a pool, known as a Collateral Loan Fund Pool, and held in the pool for a period of five years if necessary.

That the pool shall be used in providing collateral for loans to be made by a Columbus bank, at an interest rate as low "as is commensurate with sound banking practice and interest rates extant at the time loans are made", to meritorious returning veteran members of the

Academy who may call for necessary financial assistance.

That the pool shall be under the supervision of the Veterans' Committee of the Academy.

That the Veterans' Committee and the officials of the bank shall determine the necessity, reasonableness and amounts of all loans applied for.

That's the gist of the project. It's a good idea—should work. It's not a paternalistic plan but simply a sound business arrangement at a reasonable figure.

Those who may be interested in securing complete details and a copy of the agreement should write the Columbus Academy of Medicine office, 79 East State Street, Columbus 15.

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### TRUMAN ADVISED OF CRISIS IN MEDICAL EDUCATION

A memorandum pointing out that not enough physicians are being trained to meet the demands for doctors which will increase after the war and how this can be remedied has been transmitted to President Truman by a special sub-committee of the Committee on Postwar Medical Service of the American Medical Association.

This brings to light again one of the worst blunders on the part of the Federal Government during the war period, i. e., its failure to establish a suitable method of insuring a steady flow of students into medical schools, despite repeated warnings on the part of officials of the A.M.A. and medical educators.

The memorandum points out that even if admission, enrollments and graduations from medical schools should continue at the present wartime levels, only about half of the need will be met since 400,000 students will receive the M. D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus under the most favorable conditions, it is stated, only about 16,000 additional physicians will be available after the war to do the work of 30,000. Continuing the memorandum says:

"In spite of this, freshmen enrollments in the medical schools of this country will be drastically reduced within the next year. In the past year virtually no able bodied males have been permitted to commence the two-year course of college premedical studies because the Army and Navy have ceased assigning men to such studies and the Selective Service System has discontinued deferments of premedical students. In the past few years each freshman class of about 6,000 students included 4,000 to 5,000 able bodied



men. These are no longer available under existing regulations.

"This deficiency can be corrected under the present Selective Service Act as follows: Defer qualified men now in college premedical studies when they reach 18 and defer 8,000 selected high school graduates of this year to commence college studies in premedicine. From these, 4,500 should be earmarked for admission to specific medical schools a year later. Repetition of this procedure each year the war lasts would effect the training of enough doctors to care for the health of the people. Consideration might also be given to the assignment of a limited number of men now under arms back to premedical studies, provided they pursued such studies satisfactorily before induction, as far as this may be consistent with military necessity."

Every doctor now in practice, to say nothing of the public at large, has a big stake in the outcome of this serious situation.

Back up the A.M.A. on this by writing a letter to your Congressmen or to Senator Taft or Senator Burton, suggesting that they use their efforts to bring about an adjustment in the Selective Service regulations to meet this problem.

That's the least you can do and it certainly isn't unreasonable suggestion.

#### DOES THE MILITARY HAVE TOO MANY DOCTORS? LET'S HAVE THE FACTS

United States Senator Downey of California and a special sub-committee are conducting an investigation as to whether the Army and the Navy are in need of more doctors, whether or not they are making efficient use of present medical personnel, and whether or not the release of doctors for civilian practice can be speeded up.

It's about time Congress takes a look at the situation.

Downey claims the Army alone has one medical officer for every 180 soldiers in the United States. Letters from a good many medical officers, including Ohio doctors in the services, allege that they have too little to do and that much of their time is consumed with paper work. Releases of medical officers to date, it is said, have been greatly exceeded by the number of physicians just out of internship or residency who have been placed on active duty.

Of course, the Army and Navy will defend their position and will present arguments which will be hard to refute. Nevertheless, an investigation will do no harm—probably good. If you agree, drop Senator Downey a letter, stating your views.

Let's have the facts. If the military forces are hoarding medical manpower, it's time for a showdown. If they can prove they need as many medical officers as they now have, or more, let's have the real facts. The people at home who are becoming alarmed at the decrease in effective medical personnel on the home front will not be satisfied until this argument is settled with some degree of finality.

#### LABOR YELLS WHEN THE SHOE PINCHES

Labor organizations are yelling their heads off about the Hatch-Burton-Ball Bill, S. 1171, to revise the National Labor Relations Act, charging it would produce "compulsory arbitration", "regimentation of labor", "undermining of free collective bargaining", "infringement upon fundamental freedoms" etc.

Funny, how the shoe pinches when it is on the other foot.

Most labor organizations have been ardent supporters of compulsory sickness insurance, as exemplified by the Wagner Bill, and have scoffed at the medical profession for its criticism of that proposal. Right now the C.I.O. is calling for a national drive to spread interest in the new Wagner sickness insurance bill to force hearings on the measure.

Labor can't have its cake and eat it. Regimentation of medicine will eventually mean regimentation of other groups, including labor.

#### RED CROSS TO RECRUIT BLOOD DONORS FOR CIVILIAN USE

The announcement that American Red Cross Chapters throughout the nation will be permitted to recruit blood donors for civilians in conjunction with blood collection programs sponsored by recognized medical or health agencies should meet with widespread approval. The Red Cross has done a great piece of work in this field during the war. Its cooperation with medical and health agencies in activities to insure the provision of blood and its derivatives to meet civilian needs will be extremely beneficial to the work of such agencies and the public at large.

Chapters which are continuing to recruit donors for the armed forces will not participate in the civilian program at this time, according to the announcement. The blood collected and the blood derivatives produced will be made available by the Red Cross without cost to physicians, hospitals, clinics and patients.

It is hoped Red Cross chapters and medical and health agencies in Ohio will start to work at an early date. Local medical societies and health agencies should prepare now to offer the advice and guidance which will be sought.

This activity will tie in nicely with the provisions of a law enacted at the recent session of the Ohio Legislature which gives the Ohio Department of Health authority to start such a program, if needed, and to cooperate with other organizations engaged in similar activities.

The College of Pharmacy of Ohio State University is one of 58 colleges of pharmacy that share in scholarship grants totalling \$20,800, made available by the American Foundation for Pharmaceutical Education.

# Benefits of Ohio E.M.I.C. Program for Wives and Babies of Service Men Liberalized Under New Regulations

A NUMBER of liberalizing changes in the Ohio Emergency Maternity and Infant Care Program for wives and children of service men became effective July 1, 1945, according to an announcement by Dr. Roger Heering, State Director of Health. The Ohio program, which is administered by the Division of Child Hygiene, Ohio Department of Health, was revised to meet regulations of the U.S. Children's Bureau through which Federal funds for carrying on the program are furnished.

Principal changes made in the Ohio regulations, in compliance with revised Federal regulations, are as follows:

## THOSE NOW ELIGIBLE

1. Under the new regulations, individuals for whom care may be authorized are:

- (a) A woman applying for maternity care whose husband during her pregnancy was in the fourth, fifth, sixth, or seventh pay grade of the United States Army, Navy, Marine Corps, or Coast Guard or was an Army aviation cadet. If the husband was in one of these grades at any time during his wife's pregnancy but subsequently died, is missing in action, or has been honorably discharged, the wife would still be eligible for maternity care.
- (b) An infant (under one year of age) who was born to a woman during an authorized period of maternity care. The application for maternity care now includes application for care of the infant in compliance with this regulation.
- (c) An infant (under one year of age) whose mother did not receive maternity care through the program, but whose father during the infant's prenatal life or first year of life was in the fourth, fifth, sixth, or seventh pay grade of the United States Army, Navy, Marine Corps, or Coast Guard or was an Army aviation cadet. Even if the mother did not receive maternity care, the infant (under one year) would be eligible for infant care, providing the father was in the proper pay grade during the prenatal life or first year of life of the child. Also, the child would be eligible for care if the father subsequently died, is missing in action, or has been honorably discharged.

Wives and infants are now eligible for benefits if the husband and father has been promoted to a higher rank, providing he was in the proper

pay grade at any time during the wife's pregnancy or during the child's prenatal life or during its first year of life and providing all other conditions of the regulations are complied with.

## ADDITIONAL FEES ALLOWED

2. An additional payment to the attending physician or consultant for time in travel and for cost of travel in attending seriously ill patients or for home or hospital deliveries and after-care may now be authorized in an amount of 25 cents per mile each way traveled outside of the corporation limits of the place of residence of the physician.

3. If the patient is hospitalized in a hospital which does not include anaesthetic service in the hospital operating costs or if the patient is delivered at home, the services of an anaesthetist may now be authorized. A fee of not to exceed \$5.00 for anaesthesia in obstetrics or minor surgery and a fee not to exceed \$10.00 for anaesthesia for intermediate or major surgical operations may be paid.

4. If the attending physician refers a patient to a physician, a hospital, or a private laboratory for X-ray or laboratory services, a fee may now be paid, at a maximum of \$8.00 for a laboratory service; at a maximum of \$10.00 for X-ray; at \$5.00 per X-ray or other special treatment.

## TOTAL PAID OUT AND CASES HANDLED

Since the E.M.I.C. program was put into effect in Ohio in August, 1943, the Ohio Department of Health has authorized payments on 39,005 cases—36,346 maternity cases and 2,659 infant care cases, up to July 10, 1945. Applications filed totaled 43,001. To date the state has received \$4,053,171 from the Federal Government. Of this amount the expenditure of \$3,867,150 has been authorized and a total of \$2,691,088 has been paid out to hospitals and physicians.

The State Department of Taxation has begun a study of the sales tax to obtain information that will help the Ohio Senate decide whether the three per cent levy should be reduced. A report of the findings, requested by a Senate resolution, will be ready Jan. 1, 1946. Revenue from the sales tax has been increased annually since it was established in 1935, and reached a peak of \$64,237,000 last year.

A death from Rocky Mountain fever, the first caused by that disease in Ohio this year, was reported recently from Mansfield.



**"PREMARIN" THERAPY AT THE MENOPAUSE*****"The Calm of Eventide"***

It is somewhat tragic that so many women must experience a menopause that is an ordeal — thereby being deprived of the physical and mental relaxation which should come with middle age. Fortunately, estrogenic therapy can be instrumental not only in alleviating the physical distress, but also in restoring a more normal mental outlook.

The many published clinical reports on "Premarin" provide convincing evidence of its therapeutic effectiveness. Whether your patient is in the early menopause or the late climacteric, the "Calm of Eventide" is possible of attainment by means of "Premarin" therapy.

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# Death and Birth Rates in Ohio in 1944 Decline, Annual Report of Division of Vital Statistics Reveals

THE 1944 Ohio death rate of 11.37 per 1,000 estimated population, is slightly lower than the rate of 11.73 for the preceding year, according to the 1944 Annual Vital Statistics Report by Residence and Place of Occurrence, recently issued by the State Department of Health.

There were 79,868 deaths registered in Ohio for 1944, of which 43,744 were males and 36,094 females. By place of occurrence, the urban death rate was 12.7 and the rural death rate 9.1 per 1,000 estimated population. Tabulations by residence of deceased reveal an urban death rate of 11.8 and a rural death rate of 10.7. For statistical purposes, tabulations by residence of deceased disclose more accurate death rates than those by place of occurrence.

## TEN LEADING CAUSES

The ten leading causes of death in order of their importance were:

1. Diseases of the Heart.
2. Cancer.
3. Cerebral Hemorrhage.
4. Nephritis.
5. Pneumonia.
6. Tuberculosis (all forms).
7. Diabetes Mellitus.
8. Premature Birth.
9. Accidental Injury by Falls.
10. Automobile Accidents.

These causes of death accounted for 75 per cent of the deaths registered in the state.

Deaths resulting from diseases of the heart, tuberculosis, diabetes mellitus, cerebral hemorrhage, pneumonia, nephritis, accidental falls, and premature birth, decreased in 1944, while a slight increase was observed in the number of deaths resulting from cancer and automobile accidents.

There was a sharp increase in the death rate for "Accidents in Mines and Quarries", due to the Powhatan mine disaster which claimed the lives of 66 coal miners. The increase in the number of deaths from "Conflagration and Accidental Burns" is attributed to the 130 victims of the East Ohio Gas Company explosion in Cleveland during October, 1944.

## POLIO RATE GOES UP

The poliomyelitis death rate for 1944 was the fourth highest ever recorded in the state. In 1944 there were 1,172 cases of poliomyelitis reported, 88 of which resulted in death, with a death rate of 1.25 per estimated 100,000 popu-

lation. During 1943 there were 184 cases reported, with 13 deaths, for a rate of .19.

## HIGHEST AND LOWEST

Huron County, with a rate of 15.5 per 1,000 estimated population, had the highest death rate in the state; the lowest county being Pike, with a death rate of 8.3. Gallipolis reported 177 deaths, with a rate of 21.7 for the highest city. Oakwood, a suburb of Dayton, was the lowest city, having 37 deaths, for a rate of 4.5.

## MATERNAL MORTALITY DECLINES

Deaths from diseases of pregnancy, childbirth, and the puerperium for the entire state in 1944 numbered 252, the maternal mortality rate being 19 per 10,000 live births. This is a slight reduction from 1943, when 300 maternal deaths occurred in the state, with a rate of 20.9 per 10,000 live births. Tabulations by residence disclose that Wyandot County had the highest maternal death rate, reporting four deaths for a rate of 118.7 per 10,000 live births. Twenty-one counties did not have a maternal death during 1944.

In 1944 there were 5,136 infant deaths in Ohio, the death rate being 39 per 1,000 live births. The 1944 rate is the same as that for 1943, when 5,624 infant deaths occurred. Scioto County had the highest infant death rate for 1944, with 115 deaths recorded for a rate of 78 per 1,000 live births. Putnam County with 8 infant deaths for a rate of 16 per 1,000 live births was the lowest county.

## BIRTH RATE DROPS

The number of births registered in the state in 1944 was 132,531, with a rate of 18.9 per 1,000 estimated population. The 1944 birth rate is slightly lower than the rate of 20.5 for 1943. White births totaled 125,022, while non-white births numbered 7,509. The percentage of births occurring in hospitals increased in 1944 to 82 per cent. There has been a gradual increase in hospital deliveries since 1930, when only 25 per cent of the births occurred in hospitals. The City of Lockland with a rate of 34.8 had the highest birth rate of any city in Ohio, while Upper Arlington, a suburb of Columbus, with a rate of 10.4 per 1,000 estimated population had the lowest birth rate. Montgomery County with a birth rate of 24.2, had the highest rate, with Noble County, 12.2, the lowest.

Copies of the 115-page report, which was compiled by William H. Veigel, Chief, Division of Vital Statistics, State Department of Health, have been distributed to local health departments.





## EPINEPHRINE HYDROCHLORIDE 1:1000 N.N.R.

CHEPLIN solution of this powerful vasoconstrictor, hemostatic and circulatory stimulant is adjusted to a definite standard strength and is physiologically assayed by measuring the effect on blood pressure.

EPINEPHRINE HYDROCHLORIDE may be administered by hypodermic, inhalation or topical application, affording rapid relief of asthmatic symptoms, urticaria, angioneurotic edema, reactions following injections of biologicals, shock or collapse, and prompt control of certain types of hemorrhage. When used in conjunction with topical, nerve block or infiltration anesthetics, it produces a bloodless operative field and retards absorption of the anesthetic—thus prolonging the period of anesthesia.

*Literature on request*



EPINEPHRINE HYDROCHLORIDE 1:1000 is packaged in:

- 1 cc. ampules.
- 10 cc. rubber-stoppered vials.
- 30 cc. rubber-stoppered vials.
- 30 cc. bottles for topical application.

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# Interpretation and Clarification of Provisions of G.I. Bill Relative to Postgraduate Medical Training

IN a progress report of the Subcommittee on Graduate Education of Physician Veterans of the Committee on Postwar Medical Service of the American Medical Association (June 16 issue of *The Journal of the A.M.A.*, page 527) there appeared some pertinent information on and interpretations of the educational provisions of the G.I. Bill of Rights as they pertain to postgraduate medical training.

The report was based for the most part on a conference between the subcommittee and Mr. H. V. Stirling, director, Vocational Rehabilitation and Education Service of the Veterans Administration.

The following is quoted from the subcommittee's report and clarifies some of the sections of the law and regulations of special interest to medical officers:

## TUITION CHARGE MADE BY HOSPITALS

Mr. Stirling was asked whether any change had been made in the provisions previously announced in the Committee's memorandum of Oct. 16, 1944. It was there stated as follows: "The law provides that if the institution has no established tuition fee, or if the administrator deems the established tuition fee to be inadequate compensation, the administrator is authorized to provide for the payment; again, however, with the \$500 ordinary school year limitation." Mr. Stirling said that there has been no change with reference to this provision and that, therefore, a hospital may charge tuition for a residency.

Mr. Stirling's attention was called to Mr. McCarran's bill, S. 181, introduced on March 22, 1945, and now in the hands of the Committee on Finance of the Senate, the essential provision of which reads as follows: "And provided further, that if a publicly supported institution or private institution exempt from tax under section 101 (6) of the Internal Revenue Code has no established tuition fee, or if the established tuition fee of any such institution is less than the actual cost to such institution of furnishing the education or training, the administrator is authorized to provide for the payment to such institution, with respect to any such person, of the actual cost of furnishing such education or training but not to exceed \$500 for an ordinary school year." Mr. Stirling commented that this was essentially the understanding which he had of the intent of the Servicemen's Readjustment Act of 1944.

## PAYMENT OF SALARIES TO RESIDENTS

Mr. Stirling was then asked whether the previous understanding of the Committee that vet-

erans who are appointed residents in hospitals but who participate in the benefits of the G. I. bill may continue to receive a salary from the hospital. Mr. Stirling replied that there is no question in his mind but that nothing in Public Law 346 prevents either the payment of a salary by the hospital or the acceptance of a salary by the resident, provided the limitations which are recognized under Public Law 16 are applicable also under Public Law 346. He felt, however, that there should be no difficulty whatever in meeting the provisions to which he refers.

The particular provision of Public Law 16 reads as follows: "That when the course of vocational rehabilitation furnished to any person as herein provided consists of training-on-the-job by an employer, such employer shall be required to submit monthly to the administrator a statement under oath showing any wage, compensation or other income paid by him to such person during the month, directly or indirectly and based on such sworn statements, the administrator is authorized to reduce the pension of such person to an amount considered equitable and just, but not below the amount of pension or retirement pay to which he would be entitled for service-connected disability if not following a course of vocational rehabilitation."

In a memorandum of the Veterans Administration of Public Law 16 dated Dec. 15, 1943, managers are authorized to reduce the pension of a person when the employer-trainer pays wage or compensation in whole or in part if the sum thus paid "when added to the increased pension exceeds the minimum entrance wage paid by the employer-trainer to an employee in the particular job for which the person is being trained."

A provision which bears on this point is found in the Veterans Administration Instruction No. 2, dated Jan. 18, 1945, page 8, paragraph 19 (b), which reads as follows:

"Where the veteran is receiving compensation for productive labor, performed as part of his apprenticeship or other training on the job, the amount of subsistence when added to his current monthly salary or wage, based on the standard work week exclusive of overtime, shall not be in excess of the standard beginning salary or wage payable to a journeyman workman in the occupation or trade in which training is being given, similarly based on the standard work week exclusive of overtime."

## VETERANS CHOOSING MEDICINE AND DENTISTRY

Mr. Stirling was good enough to supply information concerning present trends in the num-



## In Allergic Rhinitis—

“The inhalation from tubes of volatilizable vasoconstricting drugs is often very effective. The most popular and best known of this sort is the benzedrine (amphetamine) inhaler.”

Feinberg, S.M.: Allergy in Practice, The Year Book Publishers, Inc., Chicago, 1944, "Hay Fever Treatment."

## A BETTER MEANS OF NASAL MEDICATION

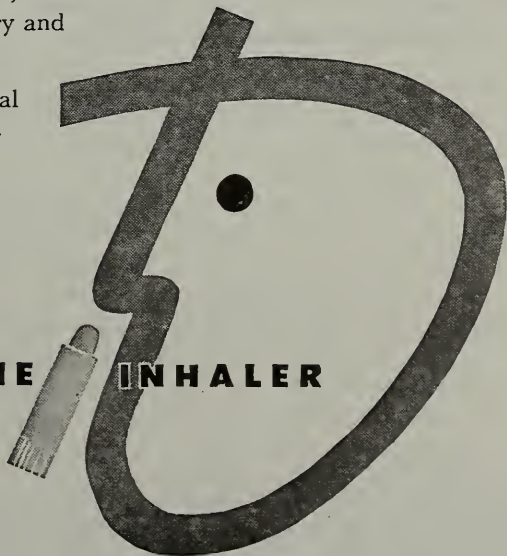
Between office treatments, the use of BENZEDRINE INHALER, N.N.R., will afford the allergic rhinitis patient marked symptomatic relief. It may, in fact, make all the difference between weeks of acute misery and weeks of comparative comfort.

The Inhaler produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine—and approximately 17% more lasting. It is, consequently, strikingly effective in reducing the congestion of hay fever, head colds, and sinusitis. Smith, Kline & French Laboratories, Philadelphia, Pa.



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ber of applications for medicine and dentistry and allied fields among the persons who had come under his office, that is, under the Vocational and Rehabilitation Service. One study had been made of a total of 9,359 applications approved by the regional offices under Public Law 16. In this group there were 38 applications requesting an opportunity to study dentistry, 81 to study pharmacy, 59 to study medicine and 18 to study chiropractic or osteopathy.

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### **Bill to Expand Provisions of G. I. Bill Is Introduced**

The chairman of the House Committee on World War Veterans' Legislation, Representative Rankin, has introduced H. R. 3749, a bill to amend the Servicemen's Readjustment Act of 1944, and it already has been passed by the House. In addition to liberalizing the loan provisions of the existing law, the pending bill would effect certain changes in the provisions relating to the education of veterans. It would provide that courses may be initiated four years after the date of the discharge of the veteran or the termination of the present war and that no course shall extend beyond nine years after the termination of the war; it would provide for short intensive postgraduate or vocational training courses of not less than thirty weeks; it would authorize correspondence courses of education or training and would increase the subsistence allowance of a veteran undergoing training or pursuing a course of education from \$50 to \$60 a month, if the veteran is without dependents, and from \$75 to \$85 a month if the veteran has dependents.

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### **Postgraduate Course for Returning Veterans Started at O.S.U.**

The College of Medicine of the Ohio State University in Columbus, Ohio, has inaugurated a plan for postgraduate training designed primarily for returning veterans and other physicians who feel the need of additional study at the postgraduate level. Physicians desiring this type of training will be required to spend full time in the University Hospital or affiliated institutions of the medical school, for a period of not less than two weeks nor longer than three months, and will be under the immediate supervision of one of the members of the faculty whom they shall select and who shall serve as a counsellor. This plan became effective on July 1, 1945. Any physician interested may write the chairman of the Sub-committee for Postgraduate Education of the Curriculum Council, Dr. B. K. Wiseman, Kinsman Hall, Ohio State University, Columbus 10, Ohio.

### **Dr. Charles F. McKhann Named Head of Pediatrics at Western Reserve**

Dr. Charles Fremont McKhann, assistant to the president in charge of research of Parke, Davis & Co., Detroit, since 1943, has been named professor of pediatrics at the Western Reserve University School of Medicine and director of pediatrics at University Hospitals, Cleveland. He succeeds Dr. Henry J. Gerstenberger, who will become professor emeritus of pediatrics beginning with the next school year.

The appointment became effective as of July 1, but Dr. John A. Toomey will remain as acting director of pediatrics at University Hospitals until September 1. Dr. Toomey will continue at Western Reserve University as professor of clinical pediatrics and contagious diseases, and in charge of the department of contagious diseases at University and City Hospitals.

Dr. McKhann was born in Cincinnati on December 21, 1898. He obtained his bachelor of arts degree from Miami University in 1918; his bachelor of science degree in 1920, his master of arts in 1921, and his doctor of medicine in 1923 from the University of Cincinnati. He was assistant and instructor in the Harvard Medical School from 1923 to 1930, and assistant professor of pediatrics and communicable diseases in the Medical School and the School of Public Health, Harvard University, from 1930 to 1936. From 1935 to 1940 he was associate professor at the Harvard Medical School and the School of Public Health at Harvard, and professor of pediatrics and communicable diseases at the University of Michigan Medical School from 1940 to 1943.

In addition to his work as a teacher and administrator, Dr. McKhann is probably best known for his work on the feeding of children and for his work with the fractionization of serums and the use of these serum fractions in the treatment of infectious diseases. He has contributed to several textbooks and is the author of over 50 scientific papers.

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### **Gift to O.S.U.**

Twenty-five thousand dollars has been presented to the Ohio State University College of Medicine by Franz T. Stone, Columbus, in honor of the 90th birthday of his father, Julius T. Stone, former member and chairman-emeritus of the University's Board of Trustees. One gift of \$20,000 will create the Julius F. Stone Fund for medical research, the income to be used particularly for research in the field of physical medicine. The second gift, \$5,000, creates the Julius F. Stone medical fellowship for research in the division of physical medicine. The first recipient of this fellowship is Dr. William G. Myers, a research associate in the Department of Bacteriology.



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# Hospital Association Adopts Policy on Veterans Care Program; Send Your Views on This to Your Congressman

**P**LANs for the expansion of the medical and hospital care program of the Veterans Administration for a potential patient load of between 15 and 20 millions are in the making in Washington.

How a huge Federal program of this kind is to be operated and administered should be of special interest and concern to hospitals and members of the medical profession. The question requires constructive thinking. Undoubtedly, members of the Congress will welcome views and suggestions from their constituents in the hospital field and among members of the medical profession.

In order to stimulate thinking and interest among Ohio physicians, *The Journal* is publishing herewith an official statement of the Committee on Veterans Relations of the American Hospital Association and approved by the Board of Trustees of that organization, to which is appended excerpts from an editorial on this subject published in the July issue of *Hospitals*, official A.H.A. publication:

## BEST CARE MUST BE GIVEN

"The American Hospital Association has been studying carefully the federal government program of hospital care for veterans, being particularly concerned that the best in hospital and medical care be available for the large number of veterans. The federal government now has had many years of experience in operating hospitals for the treatment of veterans, and it appears that certain changes should be made to make sure that all veterans receive the best of care.

"The federal government is on record as intending to extend to veterans full hospital care for service-connected disabilities, and necessary hospital care to all veterans unable to pay for hospital care, for nonservice-connected disabilities. Government has been generous in its provision of these benefits. The primary question revolves around the best method of providing this care for the veteran.

## QUESTION OF POLICY

"With the addition of over 13 million new veterans, a very substantial portion of the population will be entitled to hospital and medical care at federal expense. The question immediately arises as to whether the federal government prefers to establish a whole new system of hospitals and whether they will produce the best care for veterans, and the effect of the establishment of such system on hospital and medical care for the balance of the population.

"The American Hospital Association believes that a method can be developed which will not only permit an improvement in hospital care for veterans at a cost comparable to experience in providing these benefits in the past, but will also strengthen and benefit the whole hospital system of the country.

## LARGE SYSTEM UNDESIRABLE

"It has been repeatedly demonstrated that satisfactory operation of a large system of public hospitals is extremely difficult. Care in such hospitals, by and large, has not been comparable to that available to the general public. Authorities in the hospital field believe that the size of hospitals should be limited, and that the best insurance of quality in medical and hospital care is a direct relationship between those who serve and the recipients of the service. This is best exemplified in the hospital field by community ownership of and interest in its hospital.

"This Association is of the opinion that for short-term and acute illnesses, the individual veteran will prefer the same hospital and medical facilities which are available to his family and other members of the community. Close proximity of family and friends is in itself an important factor, in the recovery of the veteran.

## SEVEN RECOMMENDATIONS

"The American Hospital Association therefore recommends:

"1. That the federal government continue responsibility for financing hospital and medical care for service-connected disabilities for all veterans, and for nonservice-connected disabilities when the veterans are unable to meet that expense.

"2. That insofar as possible the federal government avoid the construction of a large number of additional general hospitals for the care of veterans, and that emphasis be placed instead on the construction, expansion, and use of 'community hospitals', which will be equally available to the veteran, his family, and his neighbors.

"3. That the federal government extend to the veteran the free choice of hospital and medical care in federal or nonfederal hospitals for treatment of short-term and acute illnesses.

"4. That the federal government extend to the veteran the free choice of federal or nonfederal outpatient facilities for ambulatory care.

"5. That the federal government reimburse





## *Pediatrics through Geriatrics*

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hospitals on an equitable basis for care of veterans in nonfederal facilities.

"6. That veterans who receive treatment in nonfederal hospitals for nonservice-connected disabilities through inability to meet the cost of hospital and medical care be permitted to make arrangements for their own medical service, either through their private physicians or as available through hospital staffs, retaining the option of receiving hospitalization in a veterans' facility.

"7. That the federal government in providing care for service-connected disabilities irrespective of ability to pay, also provide for reimbursement for medical care for the veterans authorized for treatment in nonfederal hospitals.

"If the above recommendations are adopted, the veterans will receive more satisfactory hospital and medical care. By hospitalization in civilian hospitals, either presently existing or to be constructed in the future, a more limited expansion of veterans' facilities should be possible. The Veterans Administration then would find it possible to concentrate on the improvement of care for the chronically ill—tubercular, mental, and others—and to maintain a less complicated system with greater assurance of better care for the veteran."

#### EDITORIAL COMMENT

Referring to this report of the Committee on Veterans Relations, *Hospitals* offered the following editorial comments, in part:

"In studying this problem the Committee on Veterans Relations was confronted by a number of difficulties in arriving at a recommendation. Most of our membership will agree that the establishment of a large chain of veterans hospitals is unlikely to result in the best care for veterans. Such a plan is not compatible with a proper consideration for the hospital and medical needs of the families of veterans and the balance of the population. This committee was convinced that any large chain of public hospitals could not equal the quality of care given in the community hospital where local control is sensitive to the reaction of those who receive treatment.

"On the other hand, the Committee on Veterans Relations was opposed to a system which would provide federal payment for medical and hospital care for 15 or 20 million of our population. There was a strong conviction that such a system would lead to federalization, and again would be contrary to the best interests of the patient from the standpoint of maintaining quality of care over a period of time.

"The committee came to the conclusion that the matter might best be handled by making hospital and medical treatment for veterans with service-connected disabilities optional as to federal or nonfederal facilities, with full payment by the government for medical and hospital care, since veterans are entitled to this service irrespective of their ability to pay for it. However, it has been the expressed intention, as embodied in federal legislation, that veterans should re-

ceive care not only for service-connected disabilities but for nonservice-connected disabilities when they are unable to meet the cost of such care.

"It seems wise that the veteran be given the option of having the federal government meet the cost of hospital care for nonservice-connected disabilities wherever he may elect to be treated, medical service being on the basis of the veteran's own arrangement with his physician or under the usual rule concerning such admission to hospital, the veteran retaining the right, if he does not care to have such treatment, of applying for care in a veterans' facility."

#### Medical Books Needed

The Medical and Surgical Relief Committee of America, 420 Lexington Avenue, New York 17, N. Y., has received an appeal for medical books from Dr. E. L. Sevringhaus, member of the Medical Nutrition Mission in Italy. The Mission has set up in a hospital called the Polyclinica which is part of the University of Naples. The books are for the use of the Mission. Later it is intended to donate them to the Pediatric Clinic library.

The list of books requested is as follows:

R. P. Strong: *Stitt's Diagnosis, Prevention, and Treatment of Tropical Diseases*—Seventh edition. 2 volumes. Blakiston.

Conant, Martin, et al.: *Manual of Clinical Mycology*. Saunders.

Saxl: *Pediatric Dietetics*. 1937. Lea and Febiger.

Brennerman's loose leaf *Pediatrics*. Nelson, 4 volumes.

Best and Taylor: *Physiological Basis of Medical Practice*. Williams and Wilkins.

McLester: *Clinical Nutrition and Dietotherapy*. Saunders.

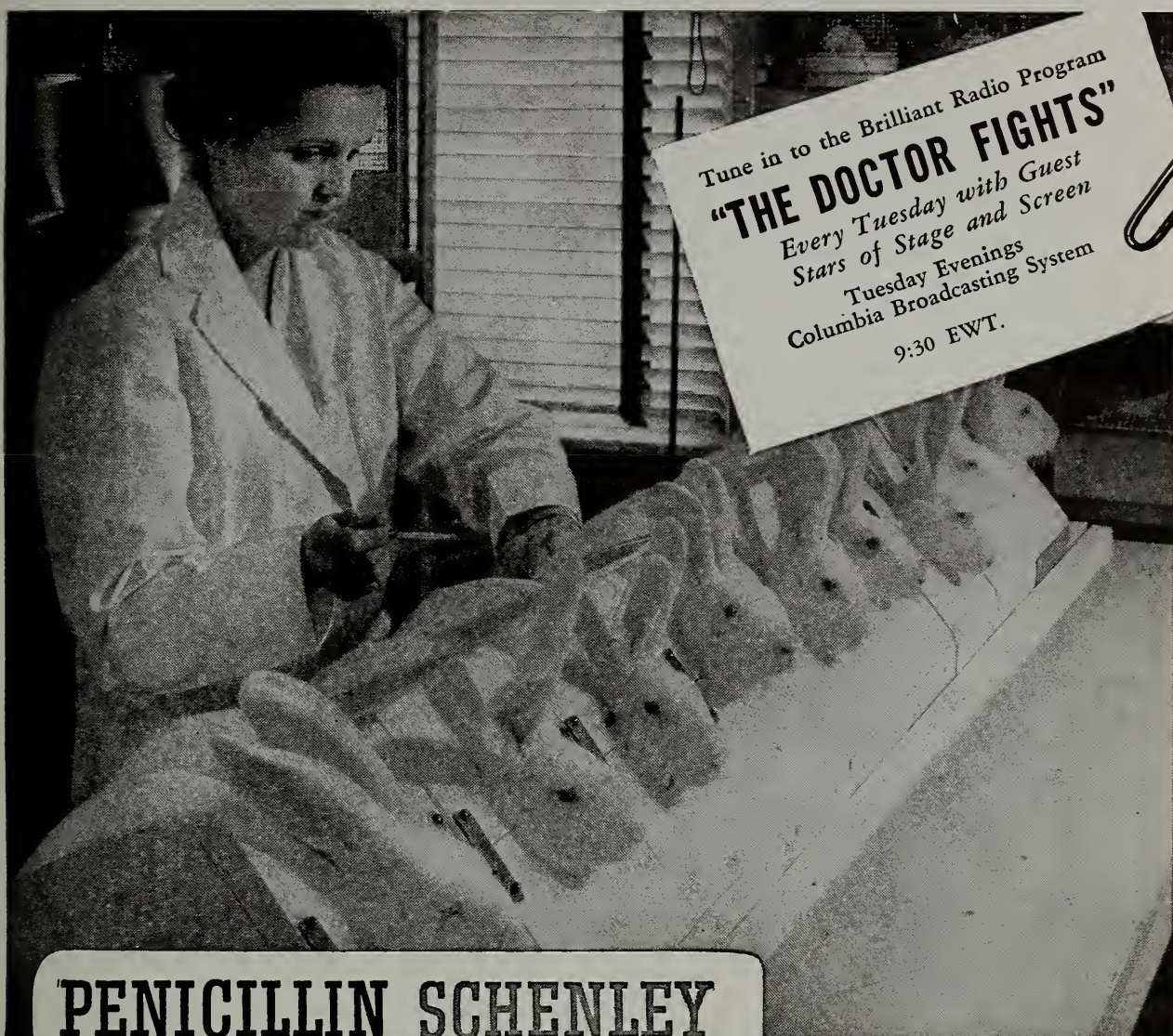
Miller: *Oral Diagnosis*. Blakiston.

Peters and Van Slyke: *Quantitative Clinical Chemistry*. Williams and Wilkins. 2 volumes.

#### Orientation Course in Clinical Allergy

The School of Medicine, University of Pittsburgh, announces an orientation course in clinical allergy to be given under the auspices of the American Academy of Allergy at the school, Bayard Street, Pittsburgh, from Monday, October 1, to Friday, October 5, inclusive. This course will include lectures, demonstrations, case presentations, and laboratory procedures covering all phases of allergy. Round-table discussions will be held each evening. The faculty will be composed of distinguished physicians from various parts of the country. The fee will be \$40.00 for physicians in private practice, while for those who are in the service with the Armed Forces or who have been discharged from such service, as well as for residents, the fee will be \$10.00. Detailed information and application blanks may be obtained from Dr. W. S. McEllroy, Dean, School of Medicine, University of Pittsburgh School of Medicine.





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# In Memoriam

Chester Bradley Bliss, M.D., Sandusky; University of Michigan Medical School, Ann Arbor, 1896; aged 72; member of the Ohio State Medical Association; fellow of the American College of Surgeons; died July 10. Active in professional and civic affairs in Sandusky for over 40 years, Dr. Bliss was a former president of the Erie County Medical Society; a charter member and former president of the Kiwanis Club; former secretary of the City Charter Commission and member of the executive board of the Local Business Association; a charter member of the Men's Literary Club; former president and honorary board member of the Ohio Public Health Association; member of the Council of the Mississippi Valley Conference on Tuberculosis. Dr. Bliss was a member of the Masonic Order. Surviving are his widow and four sons, including Lt. Col. Theodore L. Bliss, M.C., Akron, now in the Philippine Islands; Dr. Chester I. Bliss, New Haven, Conn.; and Dr. Horace H. Bliss, Detroit.

Leslie Shellabarger Brookhart, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1905; aged 65; member of the Ohio State Medical Association and fellow of the American Medical Association; died June 23. Dr. Brookhart practiced in Cleveland for 40 years. He was a member of the staff of St. Luke's Hospital, where he organized the physiotherapy department in 1928. Dr. Brookhart served in the U.S. Army during the Spanish-American War, and in World War I was an officer in the Medical Corps. He was a member of the Association of Military Surgeons of the United States. Dr. Brookhart was a charter member of the Cleveland Health Museum. He is survived by his widow, three daughters, a son, Dr. John H. Brookhart, Chicago, and a brother.

Byron Bartlett Colvin, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1908; aged 63; member of the Ohio State Medical Association and fellow of the American Medical Association; died June 20. A former chief of staff of Woman's Hospital, Dr. Colvin practiced in Cleveland for 35 years. He went overseas in World War I with the Lakeside Unit, and later transferred to a British Officers' Hospital. Dr. Colvin attained the rank of lieutenant colonel. His widow survives.

Manning Skinner Daniels, M.D., Pomeroy; Western Reserve University School of Medicine, 1925; aged 46; member of the Ohio State Medical Association and the American Medical Association; died June 14. Dr. Daniels had practiced in Pomeroy for nearly 20 years. He was a member of the Masonic Order, American Legion and

Alpha Kappa Kappa. Surviving are his widow, a son, his parents, two brothers, including Dr. Roger Daniels, Middleport, and two sisters.

John Dickenson, M.D., Cleveland; Western Reserve University School of Medicine, 1901; aged 68; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Surgeons; died July 9. The son of Dr. John Dickenson, Cleveland's first health commissioner, Dr. Dickenson practiced there for over 40 years. He had served as president of the Cleveland Academy of Medicine; assistant clinical professor of surgery at Western Reserve University; chief of staff of St. Vincent's Charity Hospital; member of the Board of Governors of the American College of Surgeons and a trustee of the Cleveland Medical Library Association. Surviving are his widow, a son and a sister.

Ross Gilbert Downs, M.D., Newark; Ohio Medical University, Columbus, 1897; aged 77; member of the Ohio State Medical Association and the American Medical Association; died July 4. Dr. Downs practiced in Newark for 45 years. He was a member of the Methodist Church and the Masonic Order. One sister and two brothers survive.

William Lewis Faul, Sr., Russellville; Cincinnati College of Medicine and Surgery, 1900; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died June 6. One of Brown County's oldest and best known physicians, Dr. Faul first practiced in August, Ky, later locating at Lawshe, Adams County, where he resided for three and a half years. He later moved to Arnheim and then to Russellville. Dr. Faul was auditor of Brown County for four years; served as clerk of the local Board of Education for a number of years, also as health commissioner of the county. He was a member of the Masonic Order, Knights of Pythias, Junior Order, Modern Woodmen and the Grange. Surviving are his widow, two daughters, three sons, including Dr. William Lowell Faul, Georgetown, and four sisters.

Sylvester Jacob Goodman, M.D., Columbus; Jefferson Medical College, Philadelphia, 1900; aged 69; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Surgeons; diplomate, American Board of Obstetrics and Gynecology; died July 5. For over 18 years, chairman of the department of obstetrics and gynecology at Grant Hospital, Dr. Goodman practiced in Columbus for 45 years. He served over-





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seas as a major in the Medical Corps during World War I. From 1920 to 1935 he was counselor for the Tenth District of the Ohio State Medical Association, and was a former president of the Columbus Academy of Medicine. His widow, a son and a brother survive.

**John Dorsey Knox, M.D., Warren;** Western Reserve University School of Medicine, 1908; aged 64; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Surgeons; died May 26. Dr. Knox began the practice of medicine in Niles in 1910, moving to Warren in 1919. He was a veteran of World War I. Dr. Knox was a member of the Warren City Hospital Staff, a member of the Presbyterian Church, a charter member and past-president of the Warren Kiwanis Club; member of the Masonic Order and the American Legion. His widow, a daughter, a son and two sisters survive.

**Isaac Celsus Kiser, M.D., Piqua;** Ohio Medical University, Columbus, 1897; aged 72; member of the Ohio State Medical Association and the American Medical Association; died June 26. A practicing physician in Piqua since 1918, Dr. Kiser previously was located at Fletcher for 28 years. In 1913-1914 he was a member of the Ohio Senate, representing the Twelfth District, and sponsored legislation which provided for the Miami Conservancy District. Dr. Kiser was legislative committeeman for the Miami County Medical Society; past-president of the Rotary Club; member of the staff of Piqua Memorial Hospital and a director of the prospective Dettmer Hospital; member of the Presbyterian Church; Masonic Order and the Elks Lodge. His widow survives.

**Charles Howard Lisle, M.D., New Hampshire;** Starling Medical College, Columbus, 1903; aged 68; former member of the Ohio State Medical Association and the American Medical Association; died June 19. Dr. Lisle practiced in Maplewood and Jackson Center for many years before locating in New Hampshire, Auglaize County, eight years ago. He was a member of the Methodist Church. Surviving are his widow and two sisters.

**William Everett Lloyd, M.D., Columbus;** Ohio Medical University, Columbus, 1905; aged 67; member of the Ohio State Medical Association and fellow of the American Medical Association; died July 12. A member of the medical staff at the State Industrial Commission for 28 years, Dr. Lloyd was previously in private practice in Columbus from 1905 to 1917. He was a member of the United Brethren Church and the Elks Lodge. His mother and two brothers survive.

**Alfred Emanuel Loyer, M.D., New Washington;** Medical College of Ohio, Cincinnati, 1895; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died June 25. Dr. Loyer retired four and a half years ago because of ill health, after having practiced in New Washington for 46 years. He was a former president and secretary of the Crawford County Medical Society. Dr. Loyer was a member of the Lutheran Church. Surviving are his widow, three daughters and a son.

**John Pascal Sawyer, M.D., Cleveland;** Western Reserve University School of Medicine, 1886; aged 83; member of the Ohio State Medical Association; fellow of the American College of Physicians; member of the American Gastro-Enterological Association and diplomate of the American Board of Internal Medicine; died June 17. A member of the faculty at Western Reserve since 1886, Dr. Sawyer retired as professor emeritus of clinical medicine and therapeutics in 1932. The University conferred the honorary degree of doctor of humanities on him in 1941. Dr. Sawyer was emeritus chief of staff of St. Vincent's Charity Hospital and was a founder and trustee of the Cleveland Medical Library Association. He was a member of Delta Upsilon and Nu Sigma Nu. Surviving him are two sons.

**Robert Benjamin Stevenson, M.D., Columbus;** Ohio State University College of Medicine, 1912; aged 56; member of the Ohio State Medical Association and the American Medical Association; died July 13. Dr. Stevenson practiced in Columbus for over 30 years. During World War I he was a captain in the Medical Corps, and was chief of the laboratory staff at an Army hospital in Hot Springs, N.C. Dr. Stevenson was a Mason. Surviving are his widow, a son and three brothers.

**Jay Dunham Thomas, M.D., Springfield;** Medical College of Ohio, Cincinnati, 1895; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died June 23. Dr. Thomas began the practice of medicine in 1896 as a physician at the Dayton State Hospital, moving to Springfield in 1898. He left Springfield in 1915 to become a member of the staff of the Ohio State Tuberculosis Sanatorium at Mt. Vernon, and three years later became director of that institution. From 1921 to 1927 Dr. Thomas was associated with the United States Veterans Bureau, with headquarters in Cincinnati. He was superintendent of the Clark County Tuberculosis Sanatorium from 1927 to 1935. Dr. Thomas was a member of the Association of Military Surgeons of the United States; the Methodist Church and the Masonic Lodge. He is survived by a daughter and two sons.



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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### CLINTON

Dr. Sigmund Federlein, Blanchester, gave a very interesting account of medical education in Germany at the turn of the century, at a well-attended meeting of the Clinton County Medical Society, July 3, at the General Denver Hotel, Wilmington. The address included descriptions of eminent teachers and instruction methods and training of that period.—R. W. DeCrow, M.D., secretary.

### HIGHLAND

Dr. J. Martin Byers, Greenfield, spoke on "Control of Pain in Childbirth", at a meeting of the Highland County Medical Society, June 6, at the Hotel Parker, Hillsboro.—News clipping.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### WYANDOT

Dr. Wayne Wheeler, Children's Hospital, Columbus, was guest speaker at the regular monthly meeting of the Wyandot County Medical Society, June 28, at the Pilgrim House, Carey.—L. S. Naus, M.D., secretary.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### STARK

Following is a résumé of meetings held by the Stark County Medical Society since the first of the year:

The January meeting was held in the Nurses' Home of Aultman Hospital, Canton. Dr. T. Burstein talked on the organization of the Army hospitals. He recently had received a medical discharge due to a coronary which he had while heading an army hospital in Africa. Election of county society officers was held at this time. Dr. L. E. Leavenworth was elected president for the coming year, and Dr. L. E. Anderson secretary and treasurer. The February meeting was a dinner meeting held at the Mergus Restaurant, Canton. The speaker was Dr. F. B. Peck, who talked on the combined use of insulin, and diabetes in general. The meeting was well attended, and was enjoyed by everyone. The March meeting was held at the Nurses' Home of Mercy Hospital, Canton, and a very interesting talk on the subject of gonorrhea was given by Dr. P. S. Pelouze, Philadelphia, about therapy that is being used today in the control of this disease. The May meeting, held at the Aultman Hospital, was a pre-dedication dinner and inspection

of the new McKinley pavillion, which has just been completed. Some very interesting facts and plans were outlined by Mr. W. W. Steele, on the board of trustees of the hospital. Dr. H. V. Hullerman of Chicago gave a very interesting talk on the future of hospitals and hospital organizations. The dinner was attended by the members of the society, their wives, and the wives of the members who are in service. The June meeting of the county society was held at the Alliance Women's Club. Lt. J. F. Callaghan, Jr., a patient from Fletcher General Hospital, gave a very interesting talk of his experiences in the South Pacific campaign, and of his opinion as to the future outcome of this campaign.—L. E. Anderson, M.D., secretary.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### WAYNE

Members of the Wayne County Medical Society, their wives and guests enjoyed a chicken dinner at Reining's Restaurant, Smithville, June 27. The society's president, Dr. George H. Irvin, Orrville, presided. A short talk was made by Dr. John J. Sutter, Wooster, county health commissioner.—R. C. Paul, M.D., secretary.

Martins Ferry—Dr. C. B. Messerly has begun his sixth term as chairman of the Belmont County chapter of the National Foundation for Infantile Paralysis.

Niles—Flying is the hobby of Dr. A. L. Williamson, who owns a Piper Coupe and has a private pilot's certificate.

Akron—Dr. R. H. Markwith, former State Director of Health, is on the industrial medical staff of the Goodyear Aircraft Corporation.

## CLASSIFIED ADVERTISEMENTS

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# WAR NOTES

It can't happen here? Well, here's what might happen, if some of our uplifting brethren had their way. Read this intensely illuminating letter from Capt. Luther W. High, Millersburg, now in Gmunden, Austria:

"The Journals have been reaching me regularly since I have been in Europe and I thought that some of the readers might be interested in what I have learned of Socialized Medicine as practiced in Russia.

"For the past six weeks my unit has been working with allied physicians in attending to displaced persons. A great majority of these people are Russians and my association with them and the Russian physicians has been very close. I have had an excellent interpreter, an engineer from Moscow, and his impressions are also very interesting.

"The people of Russia receive their medical care from state paid physicians. These men are placed in various localities by the state and they have no choice of location. They work a limited number of hours and are paid the equivalent of approximately \$120.00 a month. The great disadvantage is that the patient has no choice of physician and the physician has no assurance that he will follow any one patient for the duration of that illness. Therapeutics follow a pretty routine course and there is very little variation. The individual physician has some opportunity to take courses of postgraduate study if he so desires. During the course in medical school certain individuals are chosen who are given further training for specialties and the graduate may return to school to prepare for a specialty. However, the state determines in which locality that specialist will practice. On the whole, the Russian physicians who I have met are well-trained men.

"Even with socialized medicine, the low class and middle class Russian (yes, there are still classes in Russia) do not feel that they are getting adequate care. This I learned from my interpreter and the patients. They say that all people who can afford it, will call in a physician who is doing private practice in addition to his district practice. They always call the district physician first because if he is not called and the patient is unable to work, pay is deducted. I asked if the district physician did not resent this intrusion by another physician. The answer was 'Yes', but I was told that care is taken that both physicians do not appear at the same time. The patient not only has two physicians, but also two medications. You can well imagine which medication he takes.

"The income of those men doing private practice is approximately \$400.00 a month. It is really black market practice but the state is aware of it and no attempt is made to suppress it.

"The question of hospitalization is the same as in the U. S. The rural areas do have some hospitals but most of the patients are transported to the larger cities. Incidentally, much of this transportation is done by plane.

"There is much more to be said about their system, but to generalize, I believe I am fair when I say that the Russian people and the physicians are not satisfied with their type of medical care and that it should be a warning to those people in America, both laymen and physicians, who seek to bring a socialized medicine to an unsocialized country. It seems quite clear to me, that if that type of medicine is not satisfactory in a country like Russia where everything is controlled by the government, then surely it will not work in a democratic country like the United States."

## NAMES ADDED TO MILITARY ROSTER

| Name                  | City       | Rank                |
|-----------------------|------------|---------------------|
| Anderson, James M.    | Hamilton   | 1st Lt., U.S.A.     |
| Kiefer, N. C.         | Geneva     | Surgeon, U.S.P.H.S. |
| Koehler, Henry P.     | Findlay    | Lt., U.S.N.         |
| LaRochelle, Fredk. T. | Cincinnati | Lt. (j.g.), U.S.N.  |
| LeFever, Harry E.     | Columbus   | Lt. Comdr., U.S.N.  |
| Lee, Charles V.       | Hamilton   | 1st Lt., U.S.A.     |
| Miller, Myron D.      | Columbus   | Surgeon, U.S.P.H.S. |
| Puleo, Anthony M.     | Cleveland  | Lt. (j.g.), U.S.N.  |

## WIN PROMOTIONS

| Name                  | City               | Rank               |
|-----------------------|--------------------|--------------------|
| Boukalik, William F.  | Cleveland          | Lt. Col., U.S.A.   |
| Bowman, Earl B.       | Cincinnati         | Capt., U.S.A.      |
| Campbell, S. J.       | Bucyrus            | Capt., U.S.A.      |
| Catalano, Frank A.    | Cleveland          | Capt., U.S.A.      |
| Doering, John W.      | Logan              | Major, U.S.A.      |
| Fowler, Evan C.       | Sebring            | Major, U.S.A.      |
| Froug, Charles        | Dayton             | Capt., U.S.A.      |
| Gressle, G. A.        | Newark             | Major, U.S.A.      |
| Harris, Charles P.    | Cleves             | Capt., U.S.A.      |
| Heyde, Edward C.      | Wooster            | Capt., U.S.A.      |
| Janney, James R.      | North Baltimore    | Major, U.S.A.      |
| Klein, Harold         | Cleveland          | Capt., U.S.A.      |
| Lacksen, Frank J.     | Columbus           | Lt. Col., U.S.A.   |
| Maggied, Sol          | Columbus           | Lt., U.S.N.        |
| Meltzer, S. L.        | Portsmouth         | Major, U.S.A.      |
| Norcross, Nathan      | Youngstown         | Comdr., U.S.N.     |
| Ramey, W. O.          | Cincinnati         | Comdr., U.S.N.     |
| Rothermich, Norman O. | Columbus           | Major, U.S.A.      |
| Sabin, Albert B.      | Cincinnati         | Lt. Col., U.S.A.   |
| Searle, Clark P.      | Wyoming            | Capt., U.S.A.      |
| Shapiro, Nathan       | Cincinnati         | Capt., U.S.A.      |
| Smith, Charles M.     | Portsmouth         | Lt. Comdr., U.S.N. |
| Sternfeld, Ernst      | Toledo             | Capt., U.S.A.      |
| Treister, Bert A.     | University Heights | Capt., U.S.A.      |
| Weinberg, H. C.       | Cleveland          | Capt., U.S.A.      |

\* \* \*

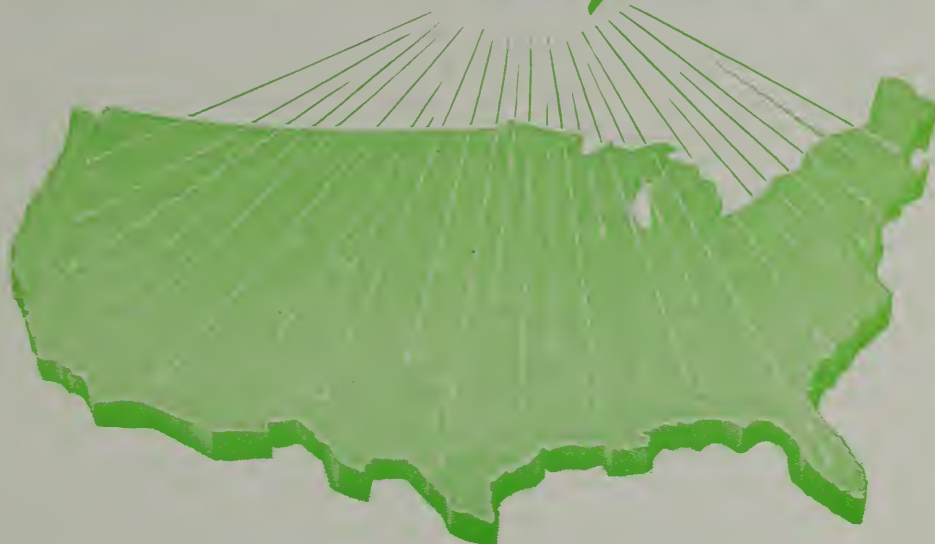
Capt. Ernst Sternfeld, Toledo, with an evacuation hospital, was in action in Germany for six weeks. He was in charge of thoracic surgery, but also took general surgical cases in rotation and consequently was quite busy. His outfit was sent from Germany to Southern France for direct redeployment to the C.B.I.

\* \* \*

New locations within the United States: Capt. Joseph Colla, Youngstown, Wakeman Gen. Hosp., Camp Atterbury, Ind.; Maj. Allen A. Cole, Logan, Woodrow Wilson Gen. Hosp., Staunton, Va.; Capt. Albert R. Zoss, Cincinnati, Finney Gen.



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\* \* \*

The Army's accumulated experience in wound management does not justify the local use of any chemical agent in a wound as an anti-bacterial agent, according to the Office of The Surgeon General. The local use of crystalline sulfonamides (sulfa powder) has therefore been discontinued except in the case of serous cavities where its use, while permissible under the di-

rection of the surgeon, is not recommended. This subject is covered by War Department Circular No. 160 as amended by W. D. Circular No. 176, 1945.

\* \* \*

Lieut. Col. Harold C. Lueth, Evanston, Ill., has been assigned as Chief of the Classification Branch, Military Personnel Division, Office of The Surgeon General. Before coming to the Office of The Surgeon General in February of this year, Colonel Lueth was Liaison Officer for The Surgeon General to the American Medical Association, with headquarters in Chicago—a post which he held for three years. He also served as Consultant in Procurement and Assignment to the War Manpower Commission. Col. Lueth entered on active duty in 1940, serving as medical instructor in the Illinois Military Area and later as Chief of Medical Service at Fort Sheridan, Ill.

\* \* \*

Called to active duty July 19, Lt. Comdr. Harry E. LeFever, M.C., U.S.N.R., Columbus, has been assigned to the staff of the U.S. Naval Hospital, Seattle, Wash., as chief of neurosurgery.

\* \* \*

Under a recent amendment to Treasury Department regulations, all military personnel returning from overseas service have an additional two months in which to meet Federal income tax regulations. Due dates for filing returns or declarations and for paying tax or estimated tax are automatically postponed until five and one-half months after the serviceman returns to the continental United States, not counting the cal-

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endar month in which he returns. Previously, such obligations had to be met within three and one-half months after a man's return. The five and one-half months' postponement is allowed all personnel returning to this country after Dec. 31, 1944. There is a further postponement if a man leaves the United States again before the five and one-half months expire.

\* \* \*

Lt. Col. Albert B. Sabin, Cincinnati, who has been stationed for the past 18 months at the Rockefeller Institute for Medical Research, Princeton, N.J., conducting an elaborate experimental study of dengue fever, has recently been assigned by the Medical Corps to continue his studies at the University of Cincinnati College of Medicine.

\* \* \*

Lt. Col. Robert N. Sparkman, Cincinnati, recently returned after 36 months in New Guinea and the Philippines, where he was chief of the surgical service of the 248th General Hospital, has been assigned to Ashburn General Hospital, McKinney, Texas.

\* \* \*

News from the Fronts about Clevelanders, courtesy of *The Bulletin of The Academy of Medicine of Cleveland*: Surgeon of the III Fighter Command, Drew Field, Fla., Lt. Col. Carl E. Zeithaml has been in the service over four years, including 15 months as a fighter squadron surgeon and service group surgeon in Australia and New Guinea. . . . Writing from Germany, April 28, Maj. Fred Kelly with the 9th Army, comments: "It's one hell of a job keeping up with these Yanks when they start rolling. . . . The war moves on to Berlin, and the slaughter continues. Nothing but death, destruction, and chaos meets the eye as we move from place to place. If I can emerge from this with my sense of values and continued regard for life, emotion and property, there's hope." . . . Lt. Col. Wm. F. Boukalik, also with a hospital unit in Germany, says: "It would make your head swim to see and hear some of the atrocities committed by this one-time civilized nation. . . . Maj. William Dreyfuss, Capt. Myron Crawford and Lt. Whiting, all on the staff of the 178th General Hospital, situated in a modern French hospital built with American direction after the last war. . . . Capt. Myron G. Hill, with a base hospital in England, packed and ready to move. . . . Lt. A. H. Schumacher, in the Russell Islands. . . . Capt. M. L. Battles, helped patch up a completely wrecked base in Tunis and came out with a typical A.T.C. overseas installation. Then there was six months on new construction in the Arabian Desert. He says Casablanca is definitely a relief from the deathly still, hot and humid Persian Gulf area.

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Highlights for Sept.

\* INHALATION OF PENICILLIN AEROSOL IN PATIENTS WITH BRONCHIAL ASTHMA, CHRONIC BRONCHITIS AND LUNG ABSCESS: PRELIMINARY REPORT—Annals of Internal Medicine

\* THE TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS WITH PENICILLIN—Annals of Internal Medicine

\* PENICILLIN THERAPY IN SKIN INFECTIONS—Canadian Medical Association Journal

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Dr. Joseph T. Wearn, Dean of Western Reserve University School of Medicine, Civilian Consultant to The Surgeon General, returned recently from an extended nutritional survey of the islands in the Pacific Ocean Area with Col. John B. Youmans, Director of the Nutrition Division, Preventive Medicine Service, Office of The Surgeon General. Before returning home they arranged for a study to be made on the nutrition of troops in the area and on diseases which might have a nutritional origin.

\* \* \*

Capt. Maurice B. Rusoff, formerly chief of medicine at Dibble General Hospital, Menlo Park, Calif., has returned to civilian practice and is located at 677 N. High St., Columbus. He will specialize in internal medicine.

\* \* \*

Recently returned from England, Maj. G. A. Gressle, Newark, has been reassigned to duty at McClelland Field, Pasadena, Calif.

\* \* \*

The 1945 membership card of Lt. Comdr. A. E. Bennett, Cleveland, did not reach him until June because of his meanderings in the Central Pacific Area, and transfer to duty on another ship. He was in on the early stages of the Okinawa invasion. Dr. Bennett has seen three Ohio physicians, "all in good health": Col. Ralph T. Stevenson, Dayton; Lt. Comdr. Dean Sheldon, Sandusky, and Lt. Ralph Bone, Cleveland.

\* \* \*

Lt. Comdr. Eugene F. Pfanner, Dayton, formerly on sea duty in the Pacific, is now at the U. S. Naval Hosp., Oakland, Calif.

\* \* \*

Out on Guam with a B-29 Group is Capt. Russell F. Wiggers, Cincinnati.

\* \* \*

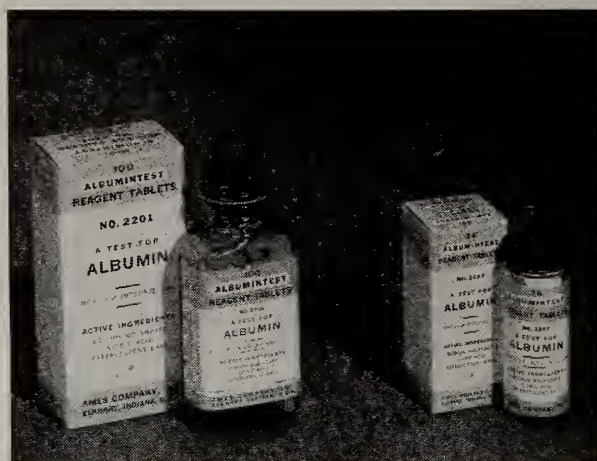
Capt. Gardner G. Bassett, Cleveland, has called our attention to an error in War Notes section in the June issue. Quoting from the *Bulletin of the Cleveland Academy of Medicine*, we had him in Belgium. Says he: "That item must refer to Capt. Garry G. Bassett of Cleveland. I have been fighting in the 'Battle of Nebraska' since April, 1944, having been transferred from the A.A.B., Salt Lake City, to Lincoln, Nebr., and then transferred to Kearney A.A.F., Nov., 1944, to become chief of the surgical service at the station hospital."

\* \* \*

Dr. N. C. Kiefer, Geneva, has been commissioned a surgeon in the U. S. Public Health Service, Regular Corps.

\* \* \*

Lt. Melvin F. Yeip, Euclid, 34 months in the service, including 22 months overseas with the Second Marine Division, was home from the



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Marianas Islands on furlough. His new assignment is at the Naval Dispensary, New Orleans.

\* \* \*

Capt. Peter Lancione, Bellaire, is chief of X-ray with a station hospital at Mindanao, P. I.

\* \* \*

Lt. Col. C. M. Dougherty, New Philadelphia, has been home on a 30-day furlough, after serving 28 consecutive months at a general hospital in Iran. He will report to Ft. Lewis, Wash., for further assignment.

\* \* \*

Recently promoted, Maj. Martin B. Taliak, Berea, has been stationed in New Caledonia for over two years.

\* \* \*

Here and there with Cincinnatians in the service, from *The Cincinnati Journal of Medicine*: Lt. Daniel V. Jones, with a Marine Service Squadron on a 250-acre island in the Western Carolines. Many ships put in at his base, one of them a seaplane carrier from Admiral Halsey's Third Fleet, with Comdr. W. O. Ramey, as chief medical officer. On a recent visit to Guam with 20 patients, Dr. Jones visited with Lt. Comdr. J. C. Danahy and Lt. Arthur H. Spreen. . . . Capt. J. H. Dornheggen, recipient of the Bronze Star Medal, has been flight surgeon with the 378th Fighter Squadron since it was organized in 1943. After seven months in England, he went with his group to Brittany, thence to Rheims and later to a small town near Verdun. The group has won six battle stars and two Presidential citations. . . . Col. Ira A. Abrahamson, C.O. of the 188th General Hospital in England, commended in *The New York Sun* for his popularity at the hospital, in an article which says that the people there call him "the best unofficial Ambassador America has sent to England". . . .

After 30 months in the Pacific, four at Kenohia Bay in Oahu and 26 months as chief surgeon at the Palmyra Base Hospital, Lt. Comdr. Gerald H. Castle is doing surgery at Great Lakes, and expects to return to the Pacific in August. . . . Capt. Paul J. Graham, physician to the reconstruction engineers attached to the Army in Italy. . . . Capt. N. G. Amato, flight surgeon at a base in India in the Himalaya Valley and tea country. . . . Lt. (j.g.) Howard M. Schriver, in the west Pacific combat area, as a divisional medical officer for a mine sweeping outfit of four boats. . . . Lt. C. C. Sonnemann, doing orthopedic surgery at the U.S. Naval Hospital, Bremerton, Wash., and recently married to Jewel Cunningham of Los Angeles, a nurse on duty at the same hospital. . . . Comdr. Herbert P. Lyle, chief medical officer of the hospital on a transport. . . . Lt. Col. George Renner, Jr., chief of medicine of the 25th General Hospital, located in Belgium

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since Christmas, with many Cincinnatians as associates. . . . Capt. Albert E. Flagge, formerly in charge of anesthesia at a 3,000-bed hospital in New Guinea, now at Ashburn General Hospital, McKinney, Texas. . . . Capt. J. Sterrett Caldwell, for almost three years chief of anesthesia at Truax Field Regional Hospital, Madison, Wis. . . . Recently transferred there is Capt. Henry C. Beekley, director of convalescent training. . . .

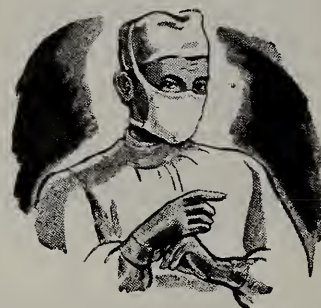
Capt. R. E. Raitz, in India awaiting reassignment after duty in the Persian Gulf Command. . . . Maj. Charles U. Hauser, recently orthopedist at Deshon General Hospital, Butler, Pa., transferred to Ft. Knox, Ky., as chief orthopedist for a new general hospital unit being organized there, presumably for overseas duty. . . . Capt. Joseph J. Bell, flight surgeon with the 29th Tactical Air Command, first stationed in the Lake District in England; thence to Chantilly, France; Liege, Belgium; Maastericht, Holland. Crossed the Rhine at Wesel and while in Germany saw service at various points including Munchen-Gladbach, Munster and Braunschweig. . . . Chief of the stomach disease ward in a general hospital located along the Stilwell Road in Assam, India, is the assignment of Capt. Harry Lapirow. . . . Capt. L. Courtney Jack, recently in San Francisco on a special mission, but expects to be out of the country soon. . . . Capt. John W. Hauser, urologist for the 38th Station Hospital in England for 27 months, and injured in an automobile accident there, is a patient at Wakeman General Hospital, Camp Atterbury, Indiana. . . .

Maj. Kenneth B. Hanson, Brooke General Hospital, Ft. Sam Houston, Tex. . . . Lt. Comdr. Mendel Zeligs, continues to report interesting experiences from Hawaii. . . . Lt. Comdr. Meyer A. Zeligs, for the past 14 months at the neuro-psychiatric unit of the Marine Barracks, Klamath Falls, Oregon. He participated in a symposium on the treatment of peptic ulcer, discussing the psychosomatic aspects, when the Southern Oregon Medical Society met at Klamath Falls recently. At the same meeting, Dr. Zeligs gave a paper on "War Neuroses", including a demonstration of the use of pentothal in the treatment of certain psychiatric casualties.

\* \* \*

Two graduates of the Ohio State University College of Medicine who have been members of the Regular Army since graduation were recently decorated with the Legion of Merit by Maj. Gen. Paul R. Hawley, another Ohioan, chief surgeon in the E.T.O. They are: Col. Paul S. Fancher, O.S.U. '30, and Col. Daniel J. Sheehan, O.S.U. '36. Col. Fancher, who was in command of the Station Hospital, Fort Hayes, at the time of the attack on Pearl Harbor, went overseas in February, 1944, as commanding officer of the 76th

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\*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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General Hospital. He is now chief of the rehabilitation division for the European theater. Decorated for his work as commanding officer of the 56th General Hospital, Col. Sheehan has been overseas since last October.

\* \* \*

Formerly chief of surgery at the Naval Air Station, DeLand, Fla., Lt. Comdr. Chas. M. Smith, Portsmouth, is now on the surgical service of the new 1,400-bed Naval Hospital being opened at Palm Beach, Fla.

\* \* \*

Lt. Col. Sloan J. Wilson, Columbus, sends his new address with a general hospital, "somewhere in Luzon". He has visited Manila.

\* \* \*

Lt. Col. Carl S. Junkermann, Columbus, has been awarded the decoration of Knight Officer of the Order of the Crown in Italy for outstanding services with a Technical Supervision Regiment in Italy. The award was made in person by Prince Umberto of Italy at the Royal Palace in Rome. Col. Junkermann is senior supervisory officer of the medical units of the Technical Supervision Regiment which was formed to supervise the activities of Italian troops in the performance of essential services of supply tasks for the Peninsular Base Section.

\* \* \*

Capt. Bert A. Treister, University Heights, was recently transferred from the Station Hospital, Ft. Knox, Ky., to Fletcher General Hospital, Cambridge, where he is chief of the physiotherapy section.

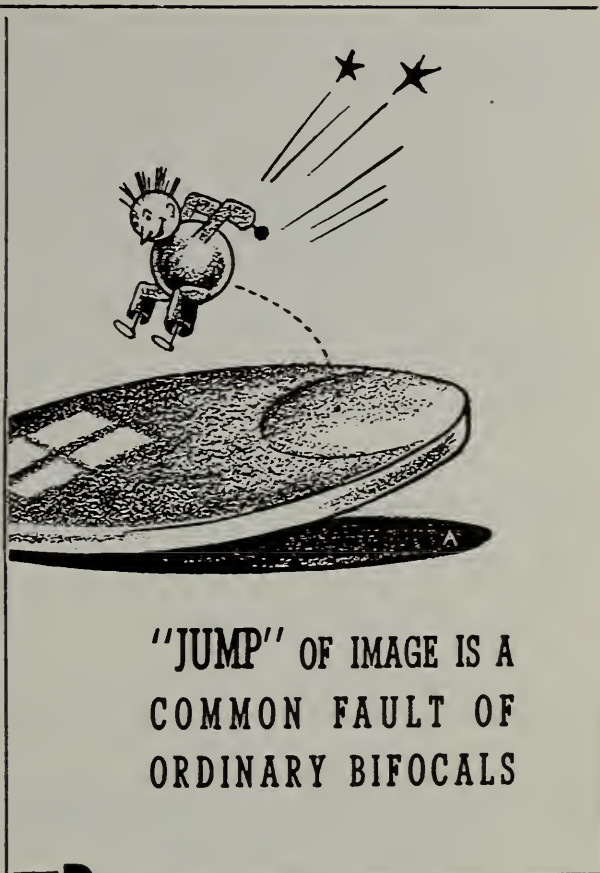
\* \* \*

Since he came back from Iwo Jima to somewhere else in the Pacific, Lt. W. L. Strohmer, Cincinnati, has been made commanding officer of Co. B of the medical battalion attached to the "glorious Fifth Marine Division". While on Iwo Jima, where he "had plenty of work to do", he was chief of surgery of Co. A in the same outfit.

\* \* \*

Maj. Floyd A. Potter, Toledo, in the office of the Military Air Attache, United States Legation, Stockholm, Sweden, acknowledging receipt of *The Journal*, has this to say:

"It was very interesting to read what the Ohio men are doing in their particular spot of the globe. I am afraid I have had no such excitement. Life in England was fairly settled when I arrived there early in 1944. Other than a little flying I happened to do, nothing was too unusual. Sweden, of course, being a neutral country was at least a little unique. I had quite a time getting used to bumping elbows with Germans and Japs. I always had the urge to bump something else. I could never figure out what they had to be so arrogant about. Even the Swedes were not afraid of them when I arrived last September. I also had quite a bit of fun helping the Norwegian and Danish underground.



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Their medical men were quite active in Sweden. We can well be proud of the work those colleagues in the underground were doing. I suppose my major duty was taking care of the internees. We had a lot of them last year. The Swedes gave me permission to practice medicine, a concession not usually given a foreign physician, and I turned out to be a country doctor, the country being all of Sweden as we had men all over the country. It has been fun, but I am now ready to come home for a while."

\* \* \*

Lt. Col. Maurice A. Schnitker, chief of the medical service at Valley Forge General Hospital, Phoenixville, Pa., has left for an overseas assignment.

\* \* \*

Lt. Col. Bernard L. Pelton, Toledo, who went overseas in Oct., 1942, as surgeon of the first P-47 fighter group to see action in the Southwest Pacific, is now medical inspector to the Far East Air Service Command. He has been on active duty since Feb., 1941.

\* \* \*

Col. Neville H. McNerney, Cleveland, after three years in England is home awaiting reassignment. Originally commanding officer of the 52nd General Hospital at Kiddminster, England, he later was in charge of the 804th Hospital Center, which included 14 hospitals in Western England, Northern Ireland and Scotland.

\* \* \*

Among Ohio medical officers on Okinawa are Maj. O. D. Ball, New Lexington, and Capt. William G. Meyer, Columbus, with a field hospital.

\* \* \*

Back in the states and anticipating a 20-day leave, Lt. Comdr. C. B. King, Canton, has been "all over the Pacific and took part in the Lingayan Gulf and Iwo Jima invasions". He recently had a change of duty to senior medical officer aboard another ship, and expects to go out to sea again soon.

\* \* \*

Lt. Col. Arthur F. Dorner, Akron, was recently transferred from Merced, Calif., to Williams Field, Chandler, Ariz., where he will assume the duties of post surgeon.

\* \* \*

Maj. J. F. Borelli, Hamilton, has been in the Pacific Theater for five months with a general hospital unit.

\* \* \*

At the same hospital on Guam as Lt. E. L. Jackson, Shelby, are Lt. R. T. Warburton, North Canton; Lt. (j.g.) Clarence V. Porterfield, St. Clairsville; and Lt. (j.g.) Happle, Toledo.

\* \* \*

Maj. Emil C. Oberson, Cleveland, has been decorated by both the American and French Governments. Here's the story from the Public Relations Officer of the 49th Field Hospital:

"In an announcement by Hq., 66 Inf. Division,

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the Bronze Star Medal was awarded Maj. Oberson for meritorious achievement in connection with Military Operations against the enemy during the period from 1 January 1945 to 8 May 1945; during which time he was acting in the capacity of Commanding Officer and Chief of Surgical Service in the 2nd Hospitalization Unit of the 49th Field Hospital. The unit was in support of divisional operations in Brittany, France, during the period covered in the citation.

"Announcement was also made of the award of the Croix de Guerre with the Bronze Star to Maj. Oberson by the French Government along with the Citation of the Order of the Brigade which is quoted as follows:

"Maj. Oberson, surgeon of the Medical Corps, US Army: He treated with greatest devotion an innumerable number of F.F.I. soldiers, and French civilians during the liberation, and has saved countless numbers from certain death. He proved this fact with the highest conscientious professional and military services."

"Prior to entrance on active duty in March, 1942, Maj. Oberson maintained a private practice on the west side of Cleveland. He was also, at this time, serving on the staff of St. Alexis Hospital, Charity Hospital, and Evangelical Deaconess Hospital. Before the outbreak of the war, Maj. Oberson was a reserve officer in the Coast Artillery Anti-aircraft, but transferred to the Medical Corps upon entering active duty at Fort Hayes, Ohio.

"Maj. Oberson has been a member of the 49th Field Hospital since 13 January 1944, and entered foreign service with this unit 27 February 1944. While a member of this organization, he occupied the position of Commander of the 2nd Hospitalization Unit along with his duties as Chief of Surgical Services."

\* \* \*

Dr. Myron D. Miller, superintendent and medical director of the Franklin County Tuberculosis Hospital for 12 years, has resigned, effective August 15, to enter the tuberculosis control division of the U.S. Public Health Service, as a surgeon in the regular corps. He will be stationed at Bethesda, Md.

\* \* \*

A recent arrival in New Delhi, India, where he is with a dispensary unit, Capt. John S. Meyers, Versailles, was ordered to 16 different posts in this country in less than 31 months. He entered Army service in Sept., 1942.

\* \* \*

"What we hear", about Dayton medical officers, from the News-Letter of the Montgomery County Medical Society: In the E.T.O. with a general hospital unit, the only decoration Maj. E. F. Damstra cares about is a "white handkerchief in his left coat pocket". . . . Comdr. Arthur M. Culler, very busy, operating five days a week—boys from Okinawa. . . . Capt. L. J. Lohr, at Langley Field, Va., doing obstetrics. . . . Billed in a chateau in Orleans, the home of Joan of Arc, 30 miles from Paris, is Capt. Conrad Clippinger. . . . Capt. Ted Light, after returning to the States, was in New York for a while, then Randolph Field, Texas, and now in St. Petersburg,

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Fla., for a ten weeks' course in psychiatry. . . . Comdr. Abe Cline, on his second trip to the Pacific, and another interlude from Ob. Gyn. . . . Lt. Comdr. W. B. Taggart was 12 weeks without mail while his outfit was getting to its destination from Luzon, P.I. He is senior medical officer, which "entails little medical work but liberal use of the pen". . . . Capt. Walter A. Reiling, in the E.T.O. for 27 months with the 68th General Hospital, which has established quite a reputation as "hospital setter-uppers", as the present one is number seven that they've started from scratch. . . . He reports that Capt. Phil Champion was transferred several months ago and is now chief of the section of septic surgery of the 197th General Hospital. . . . Maj. Fred Miller, chief of surgical service of the 61st General Hospital, in England.

\* \* \*

Capt. F. W. Anzinger, Springfield, in India with the A.A.F., has been awarded the Bronze Star for service in the Central-Burma campaign. He reports hot weather, with a temperature of 124 degrees in the sun one day, and 104 in the shade! Capt. Anzinger had a "wonderful trip" over the Himalayan Mountains, and liked the cool climate in China.

\* \* \*

Home for 30 days are Lt. Col. Claude S. Perry and Capt. Joseph H. Shepard, both of Columbus. Col. Perry, on active duty since Dec., 1940, has been in England, France and Belgium for the past 18 months as chief of E.E.N.T. in a general hospital. Capt. Shepard has been three years and three months in the Army, including 14 months of rugged duty in France and Germany with a regimental medical detachment.

\* \* \*

Maj. Theodore C. Allenbach, Columbus, is commanding officer of an Army convalescent hospital on Saipan.

\* \* \*

Lt. Comdr. Edward Friedman, Cincinnati, has traveled 32,000 miles aboard ship in the Pacific since last October. He was at Iwo and Okinawa.

\* \* \*

Previously at the American Hospital, Reims, Maj. Harry Goldstein, Cincinnati, is now with the 99th General Hospital at Verdun, France.

William C. Wendt, one of the founders of the Wendt-Bristol Drug Company, Columbus in 1903, and a familiar figure at Ohio medical meetings for many years, died last month. He was 73 years of age. As a representative of Franklin County in the Ohio General Assembly from 1921 to 1931, Mr. Wendt was one of the "wheel-horses" for organized medicine.

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### Special Rules for Sending Rabies Specimens To State Laboratory

Special instructions regarding the shipping of dog heads to the Ohio Department of Health Laboratories for rabies examination and information which should be transmitted on such cases have been issued by State Health Director Roger Heering.

The following directions should be followed by those sending specimens for rabies examination in order to minimize confusion and mistakes:

1. All specimens for rabies examination and all information regarding them should be sent to:

Division of Laboratories  
Ohio Department of Health  
Ohio State University Campus  
Columbus 10, Ohio

2. Send by express only—specimens are not to be sent by mail.

3. To insure that a head of an animal will arrive at the laboratory in good condition, provide enough ice or dry ice in the container with the animal head to assure a low temperature. It is necessary to send a double container when ice is used. The inner small metal compartment must be water tight. The ice is packed around the inner compartment in a larger outer can, which must be water tight when kept upright. A cardboard box can be used with dry ice. Precautions must be taken not to place dry ice next to the head. If the animal head is wrapped in several layers of paper, this will prevent freezing. If dry ice is placed directly in contact with the specimen, it may necessitate a delay to allow the specimen to thaw out.

4. Telephone or telegraph the laboratory whenever a rabies specimen is being forwarded. If the situation does not warrant immediate notification, a special delivery letter giving all the essential facts, will suffice. Enough information should accompany the animal head to allow the return of a complete report. The description of the animal should include coloring and breed. Also provide the owner's name and the names of all persons bitten or exposed.

5. In urgent cases, when persons have been bitten about the face or head, send the animal's head to the laboratory by messenger. Express delivery is often delayed. This is especially true at week-ends and on holidays.

6. Labels should be carefully affixed so that they will not be lost or destroyed.

A practicing physician in Portsmouth for 24 years and more recently assistant medical director of the Stonywood Sanatorium, Lake Kushaqua, N.Y., Dr. Frank C. Beeks has been appointed superintendent of the Mt. Logan Tuberculosis Sanatorium, Chillicothe, succeeding the late Dr. B. L. Chipley.

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# Do You Know - - -

Dr. Edward J. McCormick, Toledo, is the new chairman of the Council on Medical Service and Public Relations of the American Medical Association.

\* \* \*

Lt. Col. Hardy A. Kemp, M.C., former Dean of the Ohio State University College of Medicine, and now secretary of the Army Medical School, Washington, D.C., has been appointed Dean of the Wayne University College of Medicine, Detroit.

\* \* \*

The annual scientific and clinical session for 1945 of the American Congress of Physical Medicine has been cancelled. This meeting was to have been held in New York City, September 5 to 8, 1945.

\* \* \*

Iodine Educational Bureau, Inc., has appointed Harry J. Cordle as vice-president and director, succeeding Herbert C. Brewer, who resigned to devote more time to the business of Chilean Nitrate Educational Bureau, Inc.

\* \* \*

Dr. Robert Taylor, Indianapolis, joined the Research Division of the Cleveland Clinic Foundation on July 1. Dr. Taylor has had a wide experience in the field of internal medicine, especially having been concerned with diseases of the heart. He graduated from Northwestern University Medical School in 1939 and served his internship at the Passavant Hospital in Chicago. From there he joined the staff of Dr. Irvin H. Page at the Lilly Clinic, Indianapolis City Hospital. This association is again renewed at the Cleveland Clinic.

\* \* \*

The new Dean of the University of Vermont College of Medicine, Burlington, is Dr. William Eustis Brown, former associate professor of preventive medicine, University of Cincinnati College of Medicine, who returned to Cincinnati June 5, after serving as chief medical officer of the Balkan mission of the United Nations' Relief and Rehabilitation Administration since October, 1943.

\* \* \*

Dr. G. T. Blydenburgh, director, Student Health Service, Ohio Wesleyan University, Delaware, is the new secretary-treasurer of the American Student Health Association.

\* \* \*

Dr. Robert H. Bishop, Jr., director of University Hospitals, Cleveland, recently attended the first annual meeting of the Inter-American Hospital Association, Inc., at Mexico City as one

of four representatives of the United States on the Board of Trustees.

\* \* \*

Dr. V. N. Marsh, Painesville, well known Lake County physician and a former delegate of the Ohio State Medical Association to the American Medical Association, retired recently because of ill health. He will reside in Ukiah, Calif.

\* \* \*

One of the new members of the Board of Trustees of Central Hospital Service, Columbus, the Blue Cross plan for Central Ohio, is Dr. C. C. Sherburne, immediate past-president of the Ohio State Medical Association. Other physician-members of the Board are: Dr. J. H. J. Upham, Dr. H. A. Minthorne, Dr. H. A. Baughn, Columbus, and Dr. C. E. Holzer, Gallipolis.

\* \* \*

The term "injury" under the Ohio Constitution and the Workmen's Compensation Act, as amended effective July 10, 1937, "comprehends a physical or traumatic damage or harm, accidental in its character, in the sense of being the result of a sudden mishap occurring by chance, unexpectedly and not in the usual course of events, at a particular time and place", the Ohio Supreme Court held in reversing the Hamilton County Court of Appeals in the case of William E. Reynolds, Plaintiff-Appellee, v. The Industrial Commission of Ohio, Defendants-Appellant, 145 O.S. 389, decided June 13, 1945; Decision 29950.

\* \* \*

Dr. Gertrude E. Moulton, retiring head of the Oberlin College department of physical education for women, was honored recently by a dinner sponsored by alumnae of her department, and by announcement of the establishment of a special trust fund to provide a yearly scholarship for a student "giving a promise of developing skills and leadership" like those of Dr. Moulton. Dr. Moulton, president-elect of the Mid-West Association for Health, Physical Education and Recreation, also has been active in other professional associations in that field.

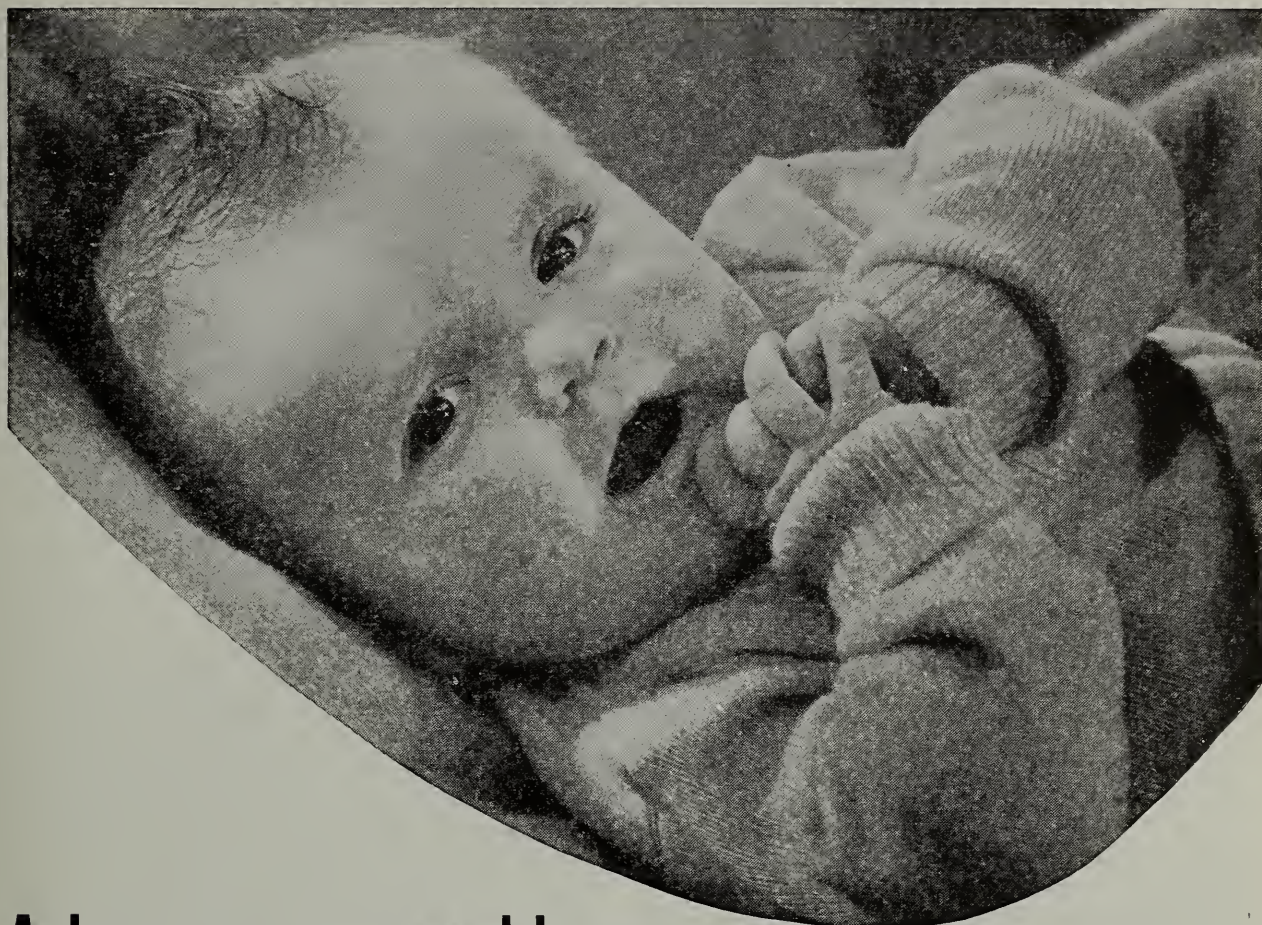
\* \* \*

George L. Coffinberry, Columbus, is the new chairman of the State Industrial Commission. Richard W. Morse, Akron, recently appointed by Governor Frank J. Lausche to succeed James A. White, is vice-chairman. Will T. Blake, East Liverpool, is the other member of the Commission. Ralph S. Locher, Cleveland, is secretary.

\* \* \*

New officers of the Academy of Medicine of Cleveland include: Dr. Farrell T. Gallagher, president; Dr. R. B. Crawford, vice-president; and Dr. Robert F. Parker, secretary-treasurer.





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# The Physician's Bookshelf

**Nutrition With Sense**, by Eleanora Sense, (\$2.00. *M. Barrows & Co., Inc, New York City*) is as clever throughout as is the pun in the title. The author's "Nutrition Primer" is well known as are her other writings, all of which add to the joy of eating. It is a sound book full of common sense and happiness.

**Rypins' Medical Licensure Examinations. Topical Summaries, Questions, and Answers.** Editorial direction by Walter L. Bierring with the collaboration of a review panel, (\$6.00. 5th Enlarged Ed. *J. B. Lippincott Co., Philadelphia*) is an excellent volume to get the candidate into the swing of such examinations. It serves to emphasize that such tests can never take the place of experience. They are essentially a stunt and their passing a trick which bears no especial relation to one's knowledge of medicine. This is a fact that all Boards of Licensure and of Certification forget. Those deluded worshipers of the academic who want to have every physician write such an examination once every five years expose their own misconception of medical skill.

**The Value of Escharotics Medicines Which Will Destroy Any Living or Fungus Growth in the Treatment of Cancer, Lupus, Sarcoma, and Any Other Form of Malignancy**, by Perry Nichols, B.S., M.D., (*Apply: The Dr. Nichols Sanatorium, Savannah, Mo.*) is the most persuasive, attractive piece of promotional literature that has ever crossed this reviewer's desk. As beautiful typography as one could wish for; defending and extolling this form of therapy with a long list of testimonials and longer lists of cured patients.

**Clinical Traumatic Surgery**, by John J. Moorhead, M.D., (\$10.00. *W. B. Saunders Co., Philadelphia*) is illustrated with over 500 well chosen pictures and sketches. The moderately sized volume of 745 pages by one who has had great experience, contains all of the information necessary to diagnose and treat the usual and most of the unusual effects of accidents and injury. Throughout the work emphasis is placed upon two cardinal principles, viz., safety and simplicity.

**A Manual of Surgical Anatomy**, Prepared Under the Auspices of the Committee on Surgery of the Division of Medical Science of the National Research Council by Tom Jones and W. C. Shepard, (\$5.00. *W. B. Saunders Co., Philadelphia*) is one of the military manuals destined to render the greatest service of all. Here are the facts of anatomy in atlas form selected and presented better than they have been before.

**Men Under Stress**, by Lt. Col. Roy R. Grinker and Major John P. Spiegel of the Army Air Forces, (\$5.00. *The Blakiston Co., Philadelphia*) is the result of the observations of these well known authorities upon hundreds of patients with acute neuroses in our Ground Forces and in our Air Force Personnel. Since restrictions have been lifted on the book notes on civilian needs have been added. It will be most helpful in understanding the returning veteran.

**The Specificity of Serological Reactions**, by Karl Landsteiner, M.D., (\$5.00. Revised Ed. *Harvard University Press, Cambridge, Mass.*) brings up to date the work of the great scientist and was just completed at the time of his death. It is therefore a must book in every library dealing with immunity and hypersensitiveness.

**Familial Susceptibility to Tuberculosis**, by Ruth Rice Puffer, Dr. P. H., being Monograph No. 3 in the Harvard series on medicine and public health (\$2.00 *Harvard University Press, Cambridge, Mass.*) is a review of the literature and experimental work, together with an analysis of considerable data upon this important subject. The author concludes that the combined evidence from siblings, consorts, parents, and children of the tuberculous and from animal experiments implicates familial susceptibility as a determinant in the development of tuberculosis, but not the only determinant for the opportunity for exposure seems to be equally important.

**His Native Soil**, by Lettie Duncan Cooke, (\$1.00. *The Wartburg Press, Columbus, Ohio*) warms the heart of those of us who stand for the decentralization of our society. It is the intensely interesting story of a wealthy bachelor whose sense of loneliness prompts him to admit, "All that I have is money. Only those are rich who are loved and have loved and their wealth pays big dividends in satisfaction and happiness." The story is about what happened to him when he returned to the countryside where he was born.

**Doctor Joel**, by Watkins E. Wright, (\$2.00. *Arcadia House, Inc., New York City*) is the story of a returned veteran who can not decide what to do with his profession or his life. In love with the beautiful society girl of New York and his own Caro'ina hills makes the plot upon which is hung a good story and some stimulating thought about post-war medicine.

**Common Ailments of Man**, edited by Morris Fishbein, (\$1.00. *Garden City Publ. Co., Garden City, N. Y.*) is a series of the contributions to this general topic that have appeared in recent years in *Hygeia*. Good book for your waiting room or to give to a lay friend.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

September, 1945

No. 9

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## A Brief Critique of Psychosomatics\*

COYNE H. CAMPBELL, M.D.

"Man is said to be a compound of soul and body. However proper this language may be in religion, it is not so in medicine. He is, in the eye of the physician, a single and indivisible being, for so intimately united are his soul and body that one cannot be moved without the other. The actions of the former upon the latter are numerous and important. They are causes of many diseases; and if properly directed, they may easily be made to afford many useful remedies. . . .

"I am aware, gentlemen, that the science which I am now recommending to you is an unpopular one, and that it is often treated as chimerical and uncertain. While it bore the name of metaphysics, and consisted only of words without ideas, of definitions and nonentities, and of controversies and the ubiquity and other properties of spirit and space, it deserved no quarter from the rational part of mankind; but the science I am speaking of is as real as any of the sciences that treat upon matter, and more certain and perfect than most of them. As a proof of this I need only call your attention to the innumerable changes that have taken place in the theories of every branch of what is called physical science, and to the improvements which have taken place in each of them within the last two thousand years. Very different is the state of the science of the mind. Most of the leading opinions and observations of Locke, Condillac, Hartley, and Reid may be found in the writings of Aristotle and Plato. . . . The reason of this certainty and near approach to perfection is obvious. The mind is the same now that it was in the time of those illustrious Greek philosophers, and, of course exhibits the same phenomena in all of its operations to the moderns that it did to them."

THESE excerpts from an introductory lecture to medical students given in 1805 by Benjamin Rush,<sup>10</sup> a teacher of general medicine, illustrates that psychological and philosophical psychiatry has undergone no changes in essential content for many years.

However, under the impetus of magical thinking by clinicians of the psychoanalytic school, physicians have been roused, as a matter of defense, from a lethargic attitude toward the importance of domestic, moral, social, and other personal components as concomitants or etio-

### The Author

• Dr. Campbell, Oklahoma City, Okla., is a graduate of Rush Medical College, Ill., in 1928; diplomate, American Board of Psychiatry and Neurology; fellow, American College of Physicians, American Psychiatric Association, and the Central Neuropsychiatric Association; and associate fellow of the American College of Allergists.

logical factors of disease, to an awareness that acknowledgment at least must be made that the physicians "knew it all the time".

It is questionable that modern psychological psychiatry is actually more "modern", or has added any pertinent information to its body of knowledge for many years.

Draper<sup>1</sup> has expressed this fact in a recent article:

"If we examine closely the structure of organismic unity which doctors nowadays seem to be striving so hard to preserve for the individual, we may find perhaps that its division resides in a contemporary medical attitude and not within the animal at all."

And again:

"In our correct professional phrasing, we are by now, no doubt, inexorably committed to the word 'psychosomatic.' The precariousness of the term, however, lies in the fact that its hoped for symbolic connotation of unity may be lost in the false belief that two separate parts in man actually do exist. The only way man has been able to deal with the imponderable forces which he has sensed to be present is by abstract words or symbols. There is, however, a peril in this process, the danger that the possible, wished for, or probable reality for which a given abstraction stands may be obscured by the poignant connotation of the symbol itself, which then takes on the fixed nature of reality."

The term "psychosomatic medicine" is a very unfortunate addition to our unscientific semantics. Loose usage of the term is a threat to modern

\*Presented at the Southwest Allergy Forum, New Orleans, April 9, 1945; and reprinted, with permission, from the May-June, 1945, issue of *Annals of Allergy*.

medical education. It would channelize potentialities and curb the natural efforts of mankind toward better understanding of illnesses that do not belong to the realm of medicine per se. There is no such entity as "psychosomatic medicine" any more than there is "psychosomatic sociology", "psychosomatic philosophy", "psychosomatic politics", or "psychosomatic mysticism".

There are no ontogenetic influences that possess potentialities of producing a reactive organic response from the phylogenetic pattern of an organism so as to characterize the response as being something on the order of a clinical syndrome which should be placed in the category of a psychiatric disability.

It is not within the professional realm of the physician to bear the burden of the connotations involved in the tenets of "psychosomatic medicine". All illnesses that may be the result of emotional conflicts are on a reality basis to the sufferer.

It is important that the physician continue his traditional orientation toward humanity and that he realize that current environmental factors responsible for the production of symptoms do not belong in his specific domain. For some reason, the physician is always a specialist in his own way. He is first a physician, second, a politician, gentleman farmer, et cetera, and if he lets the latter interests become too dominant, he no longer is really a qualified physician. The physician was then, is now, and shall be afterwards, a person who attends primarily to disturbances of the "physic".

This does not mean that he should not be a counsellor, or that he should ignore emotional problems in his patient. He should be informed of them, and advice should be given the patient regarding changes that might help, but the major proportion of symptoms that occur as the result of personal relationships involve a moral conflict. The physician-priest relationship was severed gradually many years ago. It would be hazardous for the physician to assume the responsibility of moral guidance, especially since he severed relationship with the priest, and not vice versa.

Advice regarding activities of the patient as to unhygienic attitudes are in order, but the assumption of the role of moral interpreter, with ritualistic components, as manifested by some psychiatric techniques, is not of teleological therapeutic value.

The physician who has patients with reality conflicts that produce allergic or other symptoms may deal with the problem to the best of his ability, but the patient's neighbor who is not professionally trained in anything, might, and often does indulge in counselling, solicited by the patient, with the materialization of excellent results.

There is no academic training that would be apropos. There is no educational program that would be effective so far as "psychogenic" allergic symptoms are concerned; because such a program would be a symptom tantamount to, or worse than the psychogenic allergic manifestations in those people so constituted to react in such a way.

Indulgence in retionalizations of mother, father, sister, brother, grandmother, grandfather, aunt, uncle and cousin relationships as the etiological basis of any chronic ailment is only an indication of a psychiatrist, psychologist, preacher, or like animal in trouble himself.

The herd instinct is a biological expression, not of protoplasm, but of many protoplasms that make up life. Current attitudes would indicate the inevitability of a temporary internationalism, but there is no reason to believe that the amazing modern inventions will alter the cycle of fundamental biological processes.

The psychological aspects of allergy may be dealt with by the allergist much as such problems that have existed and have confronted the family physician for ages. The "psychic" component of the autonomic nervous system disturbances is still in the realm of that wherewithal in which the unknown continues to be the unknown.

Shock therapy in the affective psychoses and in certain types of schizophrenic reactions has effected striking symptomatic improvement. It is likely that scientific studies enacted upon the basis of these results will some day give us the enlightenment regarding these most malignant and serious disorders.

The results of prefrontal lobotomy on some special cases is another indication of latent scientific progress in that branch of psychiatry.

Much time could be consumed in the elaboration upon the thesis of Benjamin Rush, in which he was of the opinion that Plato and Aristotle had fairly well exhausted the fountain of knowledge so far as the human "mind" was concerned.

During the latter part of the 19th century and the first part of this century a very potent and somewhat prolific school of magical thinking came into existence. This school of dogmatists was founded by Sigmund Freud, who became aware of the fact that physicians were not sufficiently cognizant of the importance of reality factors of a personal nature on the influence and production of certain disorders. He did not announce the discovery as such, but instead, created a term "unconscious", and endeavored to place a premium upon this category. The term was "catchy" and, as a result, psychiatrists who supposedly had acquired special ability to deal with this mystical something have, in the opinion of many, become magically bestowed with unusual conditional abilities. However, now, really, it is



believed by most that physicians, "knew it all the time".

An elaborate system of "neologisms" has evolved from this school of magic. Examples are: Superego, id, ego, repression, sublimation, displacement, oedipus complex, castration complex, penis envy, anal sadism, death instinct, identification, ambivalence, pleasure principle, lay analyses, analysand, transference, countertransference, polymorphous perversion, passive feminine traits, and dream interpretation. There are many others.

The psychiatrist, from about 1920 on, was something of an outcast, or at least a very "unfortunate creature" unless he had become subjected to the ritual of psychoanalytic training. In the opinion of the psychoanalyst, no person was capable of understanding the psychiatric disorders unless he had been "analyzed" by a qualified training analyst who had met the requirements consisting of a careful scrutiny of the dogmatists.

It is interesting that such a furor occurred, after the founder of the psychoanalytic "school" became aware of emotional factors in the production of illness. Actually, the furor came about as the result of Freud's elaborate delusional system, developed in the effort to explain many very simple phenomena.

The rationalizations and exploitations of the psychoanalysts in the treatment of emotional problems is striking. They extended their claims to cures of such conditions as migraine, essential hypertension, eczema, stuttering, transvestism, hay fever, the common cold, asthma, morphine addiction, sexual perversion, and even schizophrenia.

It is no wonder that physicians in other fields of work and that lay persons temporarily succumbed to belief and credence in such a marvelous "psychology". However, there is no doubt but that psychoanalytic technique has never cured a single case of the above-mentioned disorders.

The peripatetic philosophers of ancient Greece would throw both hands up, shake their heads, and walk away if permitted the opportunity of listening to the exchange of words during a psychoanalytic session between the "analyst" and the patient.

There was a "devil neurosis"<sup>4</sup> in the 17th century, but, undoubtedly wheals, eczema, asthma, hay fever, migraine, and blushing, and goose flesh all existed at that time.

There was the case of little Hans<sup>5</sup> who was afraid of horses in 1905, but there are many cases of little Johnnies who are afraid of automobiles and airplanes today.

Freud's explanation of little Hans' fear was that he was afraid of horses because of his incestuous wishes that he had toward mother. The horse was a symbol of father. This is only one

example of the innumerable magical explanations of phenomena offered by the psychoanalysts. Modern studies have objectified magical thinking of primitive people. The dogma of psychoanalysis should likewise be objectified.

Lewis,<sup>8</sup> in "Review of Psychiatric Progress 1944", considers Hellier's<sup>7</sup> discussion of dermatologic entities with emphasis upon psychosomatic components as being an important step. Hellier states that many cases of eczema, rosacea, falling hair, lichen planus, hyperidrosis, and warts have a predominance of psychogenic origin. He is of the opinion, however, that these reactions occur only in hypersensitive skins that overreact.

Is it remarkable that one would blush, if one had a tendency to blush, when confronted with a situation that caused blushing? Is it remarkable or even more than ordinary if one's skin has a tendency to epithelization, that it epithelializes when subjected to epithelializing stimuli?

An example of influence of psychoanalytic thinking occurs in Hellier's explanation of rosacea that occurred in a spinster after her father's death. She sat up with him almost constantly for six weeks before his death. He then died. She developed rosacea which was supposedly a symbolic expression of shame (blushing) because of her guilt over her unconscious wish that her father would die. Is it possible that fatigue of six weeks' constant attendance on her father could have played any part in this skin disturbance? The patient got well after Hellier pointed out her unconscious guilt (according to him)—but she also undoubtedly got a long-needed rest.

Dunbar<sup>2</sup> cites many cases in which she contends that fractures, hypertension, coronary disease, arthritis, and almost every type of allergic disorders have specific psychic components.

French,<sup>3</sup> upon the basis of a study of a few cases of asthma, has concluded that the asthmatic attack is precipitated by an external situation in which there is a threatened loss of security relative to a mother figure. The asthmatic wheeze to him is on the order of a stifled cry. In his cases he found that the parents overprotected the child to hide their guilt over an inner desire not to have the child. He recommends to parents, less solicitation of these children, and to the children, a more independent attitude toward the parents.

Wilson<sup>12</sup> believes that hay fever (after his analysis of seven cases) is the result of inadequately repressed olfactory sexual impulses. It has something to do about man taking the upright position, and the nose getting too far from the ground. His patients were from Victorian families who changed the child's interest from the genitals to body excretions.

Saul<sup>11</sup> states that the common cold, hay fever,

and allergy in general are manifestations of suffered intensification and frustration of passive receptive wishes with a strong oral component. Dreams presented by his patients, according to his interpretation, showed strong wishes for help from others. He states that colds would dramatically disappear when the patient acquired insight, or when frustration was alleviated. It is his opinion that colds and hay fever are perhaps closely related if not identical. However, no smears of the nasal mucosa were studied by him on any of his patients.

Fromm-Reichmann<sup>6</sup> has concluded that migraine is caused by repressed hostility toward a loved one in which the patient is not consciously aware of it. She states that it occurs in families who do not permit children to fight each other. The head is chosen as the site of the pain because it is a symbol of intellectual rivalry. (If this is not magical thinking, then the primitive who poured water over rocks to produce rain was an intellectual genius!)

It would seem to be the tendency now to place most not understood clinical syndromes into the realm of "psychosomatic disorders". Lipkin and Sharp<sup>9</sup> supply the following list:

"Cardiovascular neurosis, certain cases of hypertension, Raynaud's hyperventilation syndrome, many cases of asthma, cardiospasm, aerophagia, hyperacidity, anacidity, peptic ulcer, pylorospasm, biliary dyskinesias, mucous colitis, spastic and atonic constipation, ulcerative colitis, enteroptosis, urinary frequency, sexual disturbances, menstrual disturbances, neurodermite, urticaria, angioneurotic edema, eczema, certain cases of arthritis, certain types of headache, migraine, anorexia nervosa, and even obesity."

Let us not forget that general paresis was at one time similarly categorized.

Numerous writers have attempted clarification of clinical disorders being emotional, structural, or a mixture of both. Such classifications are essentially very loose and ill-defined.

There are many examples of physiologic reactions to emotional stimuli, and many theorize that these responses over a sufficient period of time will produce irreversible pathology. However, it remains to be proved that the responses that resulted in pathological changes were ever at any time physiological. Hypertension is a good example of this. The hypertension produces alterations in the arteries that became irreversible. But, was the hypertension that produced the arterial changes ever physiological?

There are writers who state that leukocytosis occurs on an emotional basis. Basal metabolic rates supposedly are altered by the emotions. The skin temperature drops in some people when disturbing subjects are discussed.

Treatment suggested by Lipkin consists of suggestion, catharsis, relaxation therapy, prescribed exercise, persuasion, psychoanalysis, distributive analysis, and group psychotherapy.

Psychosomatic medicine is being pushed by the

psychoanalysts who have ready magical explanations for symptoms that cannot be explained as yet upon physio-pathologic-biological scientific grounds.

It is morbidly amusing to read the psychoanalytic and other psychologic literature pertaining to schizophrenic psychoses written in the pre-shock treatment era. One would really have difficulty in differentiating the patient's "material" from the analyst's "interpretations".

The psychoanalytic technique is nothing more than a relationship between the physician and patient (if the analyst is a physician), in which both the patient and analyst indulge in mutual fantasies toward each other. The procedure finally terminates when they tire of each other or when the patient's funds are exhausted. The pseudotherapeutic results consist of an induced delusional mosaic in the patient. The analyst had the delusions before the procedure was started. It is so to speak something on the order of a folie à deux.

This is not to minimize the influence of conflict situations in the production of allergic and other clinical symptoms. Undoubtedly such phenomena do occur—but they do so just as any added strain, or worry, or other reality situation would aggravate a manifest disease process. This is no new discovery and hardly deserves any special terminology for its description. Psychiatry, the so-called "Cinderella of Medicine", is permitting itself to be overrated. It has its place in medicine, but the dichotomy of mind and body is dangerous to science.

The psychiatrist has no specially pertinent information to impart to the allergist. Every allergist knows, just as every other physician knows, that the physician-patient relationship, as per the Hippocratic Oath implies that the doctor may make an appraisal of the intimate personal information obtained.

Advice to patients relative to any reality problems or conflicts that might be enhancing his allergic symptoms does not spring from information given through the discovery of a psychiatrist. It is the *sine qua non* of the physician as a part of the art of medicine.

It is important to stress to medical students that a careful history, with special inquiry regarding the possibility of emotional problems, be obtained. Evaluation of the information is not difficult. Errors in interpretation are more likely to occur on the "psychosomatic" rather than the biologic side.

Factors in reality that add to strain in constitutionally predisposed people who suffer with allergic conditions may, theoretically, in some instances provoke an attack. Even this remains to be scientifically proved.

The famous case of Prince is frequently



quoted, in which sneezing occurred in a patient with hay fever sensitive to roses when shown a paper rose. This is not pertinent, because it was not shown that the attack of sneezing was an attack of hay fever.

Conditioned reflexes are definite entities and it is normal for one to respond with defense mechanism to irritating or danger situations. However, what would be proved if a man who was sensitive to ragweed, and who knew what a ragweed looked like, sneezed when confronted with an artificial ragweed that looked like the real McCoy?

Would Prince's patient have sneezed at the artificial rose, had he not known that he was sensitive to roses?

Some practical points are herewith given, not with the idea of being informative, but more as a space filler for the paper.

In the examination of children, to discover the existence of a pertinent emotional problem, careful inquiry should be made into the matter of adjustment between the parents. If the inquiry does not call attention to and aid in the maladjustment, treatment of any sort will only serve to make matters worse.

In the adult in which an emotional conflict is discovered, it is well to determine the nature of the conflict.

Is the problem on a moral basis? E.g., does the patient have an illicit affair? Has he cheated on his income tax report? Has he borrowed money from an opulent relative and deliberately failed to make payments on the debt? Has he been padding his expense account? Has he spread malicious gossip about a competitor? He should be asked very frankly if any moral problems exist. Expression of the fact to the physician may or may not help; but again, attention is called to the fact that such might be a factor in the illness and may bring the matter to a focus in reality and the patient sometimes will take steps to correct the situation.

Is the emotional problem arising out of the person's inadequacy? Frequently such is the case. The patient is aware of the fact, but had not connected it with the presenting symptoms. When such is found to be true, the patient should be frankly told of the situation. Improvement depends upon the ability of the patient to adjust to the passive acceptance of an altered status and changed evaluation of himself. Some can not make this adjustment. No one actually knows the reason why.

Is the emotional problem just an external situation, incidental, but inevitable, that is really overwhelming because of being a threat to the person's health, security, or other attributes of happiness? If so, nothing can be done until the external situation is altered.

This presentation has been made in the interest of medicine, with the concept that psychiatrists have no more information as to correction of social conflicts than do many other people. It is also presented in the interest of psychiatry to emphasize the above fact.

It is an extremely common, though embarrassing occurrence for the psychiatrist, after introduction, to have the person say, "Oh, you're a psychiatrist! I'm glad to meet you. I've always wanted to be psychoanalyzed. Let's go over here and sit down. I want you to psychoanalyze me right this minute."

Unfortunately, this impression and overestimation of the psychiatrist has become rather prevalent, and I'm afraid that the psychiatrist has unwittingly permitted it to be brought upon himself.

The psychiatrist is just a physician interested in the diagnosis, prognosis, further understanding, and treatment of disorders with clinical symptoms that places the patient in the category of a psychiatric disturbance.

There are no convincing reports in the literature of any allergic patients having received any more relief from psychiatric treatment than should have otherwise occurred from wise counseling with the allergist.

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The source of the spread of tuberculosis in a community is the sum total of all open cases of the disease in the locality. Consequently the greater the opportunities for exposure to open cases the higher the prevalence of tuberculosis morbidity and mortality in a community. The greater prevalence of tuberculosis in the more densely populated areas is reflected in the higher rates for children in these localities.—J. Yerushalmy, Ph.D., and C. Silverman, M.D., Am. Rev. Tbc., May, 1945.

# Current Thinking in Nutrition

JONATHAN FORMAN, B.A., M.D., F.A.C.A.

WE have made a report to the readers of this *Journal* on the program of each of these four Annual Conferences on Conservation, Nutrition, Health, and Happiness. I have had a part in arranging each of these programs—three years in conjunction with the Ohio Conservation Laboratory for Teachers, two years at Tar Hollow, and last year at Camp Muskingum on the Leesville Reservoir of the Muskingum Conservancy. This year, Ollie Fink and I arranged the program of the Fourth Conference under the sponsorship of the Friends of the Land with the cooperation of the Ohio University at Athens, Ohio. This sponsorship will now be permanent.

It is also fitting that Ohio University finally has been chosen as the home of these Conferences for the school has a noble tradition dating back to the early pioneer days and Friends of the Land are also pioneering in this project of exploring the relationship between health and the soil. An appreciation of this spirit of pioneering was fittingly expressed by one of the Faculty at Ohio University as follows:

"The oldest university building in the Northwest Territory is our own Cutler Hall, an ancient shrine of higher education built in 1817. It is a landmark to the pioneer and his attention to education. The old pioneer is gone and those who followed have left in their paths the reckless destruction of our God-given natural resources. Many areas of the nation have passed their peak and are on the downgrade. There is need for a new type of pioneer today. This new pioneer in agriculture and education is needed to restore our agriculture and husband our natural resources. It is, therefore, most fitting that this Conference which represents pioneering in this vital problem be held in the shadow of the monument to education built here by those pioneers who cleared Ohio's forest."

This concept was also expressed by Wellington Brink, Editor of *Soil Conservation*, when he wrote:

"These Annual Conferences in Ohio are pioneering in the field of soil-nutrition relationships, and indeed are pretty nearly the only source of popular current material on this subject in which there is a growing

and vital interest. I hope the time will come when home economics people, medical men, and soil conservation leaders generally will recognize this sharp relationship and will make more of it in pushing for the improvement of the quality of productive lands."

At this Conference, we were restricted by ODT to a group of 50 persons besides those who live in Athens or drove in from nearby towns and countryside. The visitors came from Florida, New Jersey, New York, Long Island, Connecticut, Pennsylvania, West Virginia, Kentucky, Illinois, Missouri, Michigan, Wisconsin, and from many parts of Ohio. They were college presidents, ministers, industrialists, physicians, dentists, soil experts, fertilizer manufacturers, editors, feature writers, novelists, free lance writers, and teachers. They came to listen, to digest, and to learn.

They learned anew the old lessons of Nature that our health is primarily dependent upon our nutrition; that the quality of our food is likewise dependent upon the soil in which it is grown; that the fertility of the soil and its nutritive qualities depend upon the amount of organic matter and essential minerals which the soil contains. A very high percentage of all life is made of air, water, and sunshine. The sunshine and the air come to the plant. Water must be provided so that it, too, can flow to the plant. This is best done by trapping the raindrops where they fall. On the other hand, while sun, air, and water come to the plant, the plant must send its roots out after the minerals which act as activators for life's chemical reactions. And so, the water and the minerals in the soil determine the health and strength of those men and animals who live upon that soil.

## THE UNIVERSITY'S PLANS

At this Conference, Dr. C. L. Dow told of the plans that Ohio University has to serve the people of the unglaciated Appalachian Plateau in Ohio. It is the purpose of the University to educate its sons and daughters and send them back to remake this region. Faculty committees have been hard at work and are now ready to use to the fullest extent the pilot tract of 5,000 acres which the Legislature voted to secure for them on Route 50 within five minutes' drive of the campus. Here, in cooperation with the Ohio Division of Forestry by the side of one of the transcontinental highways, will be a demonstration of what can and should be done with the

This is a report to the readers of *The Journal* of the thinking which this Conference inspired in me as I listened to the various speakers and in no sense is it a report of what they said. The responsibility for the thoughts here expressed rests squarely on my shoulders alone.—J.F.



eroded lands of Southeastern Ohio. It seemed to Friends of the Land that this is an added reason why they should hold these Conferences on the campus of Ohio University. Then, too, in addition to this educational park, as soon as the wartime restriction on travel is lifted a field trip through these 17 problem counties of the state will add much to the value of these meetings.

#### LAND USE

Under the title "Southeastern Ohio Adjusts Her Land Use" Dr. John Sitterly, associate professor for Rural Economics and Sociology in the Ohio State University, presented the details of the vital problem by first reviewing the conditions of the early settlements in this region. Up until the first World War the land was suitable for our level of living, but since then much of the land has been recognized as submarginal. Two-thirds of the land is now classified as suitable. The rest demands a change. Professor Sitterly gave several reasons for the fact that people are slow in bringing into effect the needed changes. The high subjective values of homes and friends makes up for the low income; subsidies have helped in improving the roads and schools, and the level of schools in southern Ohio is as good as any to be found in the country; ignorance or lack of other opportunities, the present day high standards of living, and our general economic situation make the change seem insecure. Here is a social problem and so soil conservation is not enough. He cites among the factors speeding the destruction of this area, the strain of the war, the feelings of the people, tenant operation, absentee ownership, and overvaluation of the land. Among other factors retarding the proper use of the area, Dr. Sitterly named improper education, the work of some agencies (especially the social security program), personal pride, home ties, the presence of oil, coal, and gas in the ground and direct subsidies of all types.

To one who comes from pioneer stock, which has been engaged in this Western country now for four generations in securing enough money from the land to keep themselves out of the poor house, come what may, it is no surprise that a similar spirit of thrift is being destroyed in the present generation by old age pensions and other so-called security programs, but it does please one's ear to hear a sociologist admit it.

#### THE CHURCH IN RURAL RECONSTRUCTION

To me the most significant contribution of this conference was the address of the Reverend Henry Retzek, pastor of St. Alexis Church in West Union, Minnesota. Here we got a testimonial of what a religious leader can do in a rural community. Here we heard a dynamic personality talking in the simple language of the

farm complain about the "near-Greek" in the vocabulary of the professional agricultural leader. The priest, himself, with advanced degrees from Harvard University is a paleontologist of note who has contributed to our knowledge of prehistoric man in the Northwest but to hear him talk no one would suspect these accomplishments. In his address before this Conference he taught a lesson in the use of simple language. Certainly, this is the main reason why it takes so long for the discoveries of science to become a part of the practice of the community.

The Reverend Father Retzek has accomplished a great deal in this rural community—actually increasing crops and decreasing production costs. The cutting of the production costs appeals to me as a thing of the greatest importance. Certainly, we are never going to solve the problems of rural economics by raising the price of food. The whole scheme of farming, both big and little tracts of land, must be revised in such a manner to cut the costs of production. The effort of all who serve the farmer should be pointed in this direction. Many of his practices have not changed much in 5,000 years. So some of us suspect that the horse and the mule will some day have to be replaced by a power machine that will do a lot more than just take the place of the draft animal. The farmer's net income must be raised to that of the worker.

Chemical fertilizers, uneconomic farm implements, supplemental feedings, and all of the frills with which the modern farmer is inflicted were taking 74 per cent toll of the farmer's gross income in the good Father's parish when he first took stock of the situation. Today it is all different. His farmers make a good profit not because they have acquired more land, not because they get more for their produce, but because it costs them so much less to produce. Instead of depleting their soil by mining it and selling off its vital elements to the city, their farms under his guidance, have become better and better—more fertile every year.

There are many movements in both the Catholic and the Protestant Churches for the improvement of rural life and of getting the people back on the land but I know of none that has its roots planted so deeply in the earth that looks at the problem of rural happiness so realistically as does Father Retzek's. The dramatic story of his life's work and his accomplishments, valuable as it is, is not the significant contribution he made to the Conference.

His great contribution was something much more fundamental, so much more important to an understanding of what goes on at these Conferences. Father Retzek called attention to the eternal conflict between two types of minds. It is in my field. It is in every field. In medicine it dates back to Hippocrates. Throughout

the ages medical men have been in conflict—the empiric with the rationalist. The empiric is glad to accept the accumulated experience of mankind, willing to go along in blind faith with things he could not prove if, when he tried them, they worked. Opposed to him, and not at all able to understand him, has been the scientist, who has been busily engaged in measuring and making observations of small phenomena—measuring and studying them most carefully—slowly accumulating data and slowly and painfully he has put to proof his information, put them to proof with the experimental method. That which he knows he knows beyond the shadow of a doubt. But he knows so little. He naturally is offended by one who generalizes too much, even though the generalities are in keeping with the experience of the race and show a decent respect for Nature and her rules.

So the conflict goes on through the ages. In my profession, for nearly 100 years—since Virchow turned the high power microscope on the tissues of the dead—medicine has been dominated by the rationalist and practical men have been scorned. Yet men with blinkers go in strange directions.

For instance, women who have babies in their homes are in social disgrace, yet there are many reasons why the home is a good place to have a baby. Maybe the mother is better in the hospital with its bright white atmosphere, we trust free from germs. But the baby, God help it, has been scrubbed and scoured at once to get off the "dirty grease" with which Nature has intended to protect it. So these scrubbed kiddies develop impetigo because of the scouring in a chemical bath which Nature had never prepared them to get.

Then in their loneliness in the ward with other complaining newborns they are mighty apt to develop dysentery and other distressing diseases regardless of the cleanliness and nursing care of the institution.

What is worse, something is happening to motherhood in this country and I have a feeling that much of it is because it has been a long time since the mother has been allowed to fondle, caress and protect in her arms her newborn babe. This is a violation of a fundamental rule of nature. I am wondering how mothers can be expected to establish a good flow of milk for their babies when some white robed, heavily masked individual brings in with the precision of an alarm clock for exactly five minutes a little stranger. There is a great deal of the spiritual aspects of motherhood that can not develop under these circumstances.

But we medical men are well set in our ways, especially we men of science. People watching us have come to think that they must have expensive trays of gadgets, basal metabolism, elec-

trocardiograph, X-rays, and elaborate chemical analyses the minute they feel a twinge of pain. We have failed to tell that we are using these instruments to teach and to do research and they are only needed in about one in ten persons as they come into a physician's office. So we measure and compare in the case of chronic disease while the disease progresses without doing anything to stop it. Too often there is nothing that we can do. The food we didn't eat and the food that we did eat that did not contain the nutritious elements, maybe because the soil in which they grew was not fertile—too often these things have been the real cause of the tissue degeneration which we measure and can not stop for now the machine is worn out through its misuse. Such is the conflict between the art and the science of medicine.

The good priest took time to point out the same conflict between religion and science. The forces at work are the same as I have just described for medicine. Thomas Edison invented the incandescent lamp and said the soul is not immortal; Henry Ford invented the Model-T and said history is bunk; Carlson measured hunger and announces that there is no God. There is always this conflict between the man who feels and the man who measures. So we were not surprised when the professional agriculturist was terribly put out at the man of religion who would dare lead his farmers in the week day work. What the priest had to say applies to these Conferences. We have brought men with imagination to these Conferences and there has always been some of the scientific trend in the audience who were offended because a trend was pointed out in dogmatic terms so that our people can use it. There must be men to interpret our knowledge in simple terms so that the people can use what is already known. Life is short. If we do not apply these things to the bigger problems of life, we shall all be dead and buried because we followed the current practices. We shall be dead because we waited for the rationalist to speak.

#### THE WATER PROBLEM

At all of these conferences emphasis has been placed upon conserving the rain. As Dean Orton has so aptly put it, "If we would but arrange to catch the rain drop where it falls, that would be nine-tenths of the whole job of conservation."

At our first Conference down at Tar Hallow, Dr. Wilbur Stout told us about the water table here in Ohio. He pointed out that the level of underground sweet water is a regional thing. He issued a warning to those industrial areas where this water table is sinking at a great rate and emphasized again that it is the failure to catch and hold the rain as it falls on forest and field that thus endangers our industry. For instance, in May, 1941, he stated that in that year



the steel mills of Youngstown were within 24 hours of closing down because they did not have enough water and how almost exactly one year later they were within two hours of closing because of a flood. Then, again, in the great Mill Creek industrial area of Cincinnati (where they have lots of soap and little water) the water table has gone down as much as 123 feet in some places.

Dr. Stout further said that just before the war there were at least 30 cities in Ohio whose Chambers of Commerce were trying to get industries to locate with them and in not one instance could the city have furnished water enough for any new industry to operate. Yet all of this could be prevented and an ample water supply be provided for farm and city dwellers alike, as well as for industry, if we could persuade the landowners to catch and hold two-elevenths of the rain that now rushes off to the sea carrying their topsoil with it. Nature has given us an abundance of water and it is our fault if we waste and allow our fair state to become a desert (which it well may do).

At our second Tar Hallow Conference, W. D. Ellison of the U. S. Appalachian Watershed Laboratory at Coshocton reported the results of his investigations. These place the emphasis in forming run-off water upon the force of the impact of the falling rain drop. He had proved that when a drop of rain falls directly on bare unprotected soil, it seals the surface of the soil by the force of its impact and no water can thenceforth get into the ground at that point whereas when the drop first hits the leaves of a cover crop and drips gently on to the ground, the porosity of the soil is retained and much of the rain soaks into the ground. Upon this fact depends our water supply.

Last year at Leesville, David C. Warner, water consultant to the Ohio Board of Public Works, described the advantages of impounding water in lakes and reservoirs. He emphasized the importance of impounding directly into the field through cover crops, of impounding the uplands through farm ponds and check-dams, and, finally, he pointed out the great advantages that would accrue to our state from the development of hydro-electric power from steam plants situated just below and utilizing large dams on our main rivers. The power, he maintained, that could be thus developed, would readily amortize the cost. Furthermore, it would offer decentralized employment and part-time work for the people of Southeastern Ohio, so that not only would the population of these counties be stabilized, but the people might be even induced to return to the hills. In addition to the improvement of living standards in our sub-marginal areas through a program which would pay for itself and its operation, Mr. Warner urged

this plan for what it would offer in the way of flood control and out-of-doors recreation.

This year at Ohio University, Bryce Browning, one of the founders of Friends of the Land and secretary of the Muskingum Conservancy District, told the story of what actually happens when water is impounded in a flood control program such as the Muskingum Conservancy. He pointed out that this Conservancy represents the first time that in a major project of this kind we find complete and equal cooperation between the Federal, state, and local agencies in the development of such a program.

In addition to complete flood protection for the areas below the dams, the project provides a great recreational center. This included 16,000 acres of permanent lakes with their boating, bathing, and fishing, as well as 30,000 acres of land that is being reforested for public use and pleasure. Around the lakes 365 miles of shore line which have been dedicated to public use, affording a shore line that is 50 per cent longer than the Ohio shore line along Lake Erie.

This project is being operated entirely without the use of tax money. It is paying for its own operation and is putting aside a reserve fund for repairs and expansion. A recent appraisal of this development has been made by the National Park Service and a figure for its annual recreational value to the citizens has been set at \$807,000.00. But this is real wealth and not money. It, therefore, can not be counted. In terms of human happiness and health, however, it can be readily appreciated.

So in these four Conferences, we have gained a pretty comprehensive idea of our water problem and what to do about it. It is also significant, I believe, that on the eve of this fourth Conference, the citizens of the Hocking Valley, headed by leaders from the faculty of Ohio University and Friends of the Land met and organized themselves preparatory to securing a conservancy district for the Hocking River. The Athens Forest Park with its Conservation Laboratory and Camp and this District with its lakes will add much to our future Conferences.

#### SOIL EROSION AND CIVILIZATION

On Saturday evening, Dr. Walter C. Lowdermilk, assistant chief, U. S. Soil Conservation Service, known for his writings upon this topic and the restoration of Palestine, gave a beautifully illustrated lecture showing how North Africa, Palestine, the rest of Asia Minor and Northwestern China became deserts leaving their cities buried in dust, not because of climatic changes, not because of the ravages of epidemics, but because the people depleted their soil, forgot to conserve their water, and allowed their land to wash and blow away. He left us to draw our

own conclusions: that, with our failing water supply, our erosion, our depletion, and our man-made dust storms, "it can happen here".

Dr. Lowdermilk said that the cultivated lands throughout the world are eroding faster than the new soil is being formed. This means the total destruction of the land unless measures of control are permanently worked out. Especially is this true because through modern science, the population of the world is growing at a much greater rate than before. There are no new continents to overrun and exploit. The lands of the earth have been taken in possession and so mankind must work out its salvation for the cause of abundance and peace within the limitations of the available land.

The question is, "Can the land of the earth support the rapidly increasing population?" Dr. Lowdermilk cast some doubt upon this unless proper action is taken to restore the lands. He then described the great work in which he has been engaged in Northeast China where now more than one-third of the lost land has been renewed for further use.

He said that there are in the cultivated lands of the earth 3.7 billion acres and the total amount might be stretched to four billions. This he said can not support the earth's two billion people adequately as now used. He further emphasized that in the United States wherever farmers have adopted soil conservation measures in their farming, they have had an increase of 35 per cent. Finally Dr. Lowdermilk pointed out that while the farmer is the custodian of the land, what he does with it is determined to a large degree by the social and economic pressure which the rest of the citizens put upon his shoulders.

#### MALABAR

Following Dr. Lowdermilk came Louis Bromfield to philosophize upon this land of ours in terms of his world-wide experience and the home which he has built, "Pleasant Valley". He emphasized again that money is not wealth but only a medium to facilitate the exchange of labor for services and goods. For instance, the cost of this war is not \$300,000,000,000 but rather the depletion of our soil as we ship its vital minerals in foodstuffs to distant shores, the worked-out coal and iron mines, the exhausted gas and oil wells, the slaughtered forests, and the men and women killed and maimed. These are the cost of war. We, as a nation and as individuals, must set about catching our raindrops, restoring our soil and our forests, for only in this way can we recover from this war. In this way and only in this way shall we secure for our people health, wealth, and security.

"This talk is based on practical experience with farm products, livestock, and human beings. It has been derived from over more than 40 years, with farming in relation to soil content and effect of erosion of the soil and mineral deficiencies." His success is the result of putting back into cultivation eroded, farmed-out and abandoned farmland. This implies the restoration to the soil of large amounts of organic matter and of minerals as a balance.

"Poor land makes poor people, poor people make poor land, the people get poorer and the soil gets still poorer. What I want to talk about is the relation of nutrition to productive farming.

"In view of the fact that the mineral content of the soil throughout the United States has been steadily depleted since the white man began to use it, there is need for restoration of large quantities of calcium, phosphorus, and the other minerals to the soil. Without these human health, vigor, and intelligence is impossible."

In recent years, Mr. Bromfield continued, too many of our people have become obsessed with the idea that social and economic ills can be cured by money. Real social security and real public welfare can be bought only by producing enough nutrient-rich food, enough strong fiber and enough good lumber so that each of us can have optimal nutrition, robust health, decent clothes, and adequate shelter. Indiscriminate spending of money is not the answer to the economic and agricultural problems confronting approximately one-third of the United States. In order to solve the economic and sociologic problems of much of our depleted farm lands, we must get down to the fundamentals. You can not get out of the soil what is not in it. Short cuts by way of taking vitamin pills or mineral supplemental feedings are only partially effective remedies, the full results of which are not fully known. It may be possible that in some respects these substitutes may do evil rather than good.

On the other hand, he continued, there can be no doubt about the benefits to both animals and humans of vitamins and minerals absorbed through the natural processes of food grown upon soil which contains the elements necessary for health, vigor, and intelligence. The only real answer is to "work from the ground up". There is no use giving farm machinery or new ideas or subsidies to people who are without energy, initiative, or active intelligence. It is necessary to begin with the human stock and then provide the other things after the human stock has become able to use them.

That these things can be done is illustrated by Mr. Bromfield's farm, Malabar in Pleasant Valley. Here in five years, this worn-out land has



been made to produce beyond anything dreamed of. All of this has been done in a way that any man living on the land can imitate and with the same success. Contrary to what some fear, the success of Malabar has nothing to do with Mr. Bromfield's private fortune. It is the work of Louis Bromfield using the knowledge that he had gained during his years' living in many places on this earth—more especially what he learned from the French peasants who lived on adjoining farms during the 12 years that he spent in France.

As a consequence, Mr. Bromfield came back to America with reverence for the soil and respect for Nature and Nature's God, ready to apply the sound agricultural principles of Europe. Then he ran into the fact that European agriculture just could not be transplanted to America. So he epitomized the 200 and more years of our country; he discovered in less than one year what it has taken our people so long to discover. That is, that our dashing rains, our summer thundershowers, and our climate make it impossible to do farming as it is done by the European peasant.

Then came Hugh Bennett to Malabar with his technicians. They introduced conservation practices as an aid to good land care. And so in five short years on farm land that would hardly produce at all, we find Squire Bromfield faced with the problem of abundance, too much of everything, too little storage space, too little barn room.

I personally think that this is a great lesson that can be learned from what Mr. Bromfield told the Conference, for he has never done a single thing which is beyond the fellow on the next farm—no matter how poor the other fellow may be. More and more of Richland County is being farmed after the example that he has set. Stories like this and the story of Comos Blaubaugh of Danville, who told his experiences at our Third Conference, give hope for the future.

#### FOOD HABITS

Dr. Martha Koehne, nutritionist for the Ohio State Department of Health, presented in detail for the Conference the complex problem of changing the food habits of our people for the better. Dr. Koehne pointed out that in the past we have been spending too much time giving out information and have not done enough in arousing real interest in the relation of food and food habits to the development of our bodies, our health, and our efficiency. She pointed out the important task ahead of us; the application of existing knowledge in a discriminating and active program of nutrition education; seeking out and developing channels for reaching those in the greatest need for help; further research in what should be the best methods for presenting infor-

mation on foods and nutrition most effectively. All of this boils down to what the good priest had told us the day before; that in this whole program the crying need is for clear simple statements of the truth so expressed as to motivate the citizens to do the right thing for themselves and for the rest of us.

#### BRITAIN AND FOOD

After the program of the Fourth Conference had been arranged, we were happy to get a cablegram from the Editor of *The Land*, the quarterly of Friends of the Land saying that he would be back in this country in time for the midyear meeting of the Directors of the Society to be held in Athens, Ohio, just before this Conference.

Russell Lord had been in England for over two months for OWI to see about Britain's food problem and what she had done about it and had been shown everything there by the Minister of Agriculture. We immediately wired him, asking him to come on the program and tell the Conference just how Britain had stood the war and what she was doing to feed herself. It was a dramatic story as "Russ" told it in his brilliant manner—how these had strained every sinew to produce their own food; how in prewar days they had never produced more than one-third of what they ate; how at the end of this war, although their land had been both a battle field and a flat-top for Europe, they were able by plowing up every corner, every field, hill and swamp to increase their food production to a little more than two-thirds of what they needed. In other words, had doubled their production of food in times of war; how their rationing and regimentation compelled them to eat whole wheat bread fortified with some of the essential minerals such as lime; how each child had been given some milk and so had each nursing mother and pregnant woman. The nutritionists had had their day! Calories reduced, vitamin rich foods and mineral contained foods had been increased, and Britain had finished the war with a mortality rate below anything she had ever experienced.

The question is, will she lapse back into her old eating habits in spite of the lesson that she should have learned, as Dr. Koehne's paper suggests she might. There is some evidence already beginning to appear that she may. Certainly it has been a great experiment in feeding and goes to prove the contention which has been running through these four Conferences like a thread; that the quality of our food does depend primarily upon the quality of the soil in which it is grown; that under stress by straining ourselves we can make our lands more productive.

The other question confronting Britain is how much of its soil has been depleted by this ex-

ploitation, by intensive farming and taking off so much more than could be put back, by plowing up land that should have remained in pasture. Just how badly wounded is the land of the British Isles? That is a question which only time can answer.

#### THE ADEQUACY OF OUR NATIONAL FOOD SUPPLY

For years now some of us have been insisting that most Americans did not get anywhere near enough of the right kind of food. Upon this fact we have been able to pin much of the lack of resistance to infectious diseases, many of the congenital defects, such as cleft palate, hair lip and possibly even hernia, and have accumulated an increasing amount of data to show that many, if not all, chronic degenerative diseases of late middle life—that all of these are the result of poor food and bad dietary habits. We have urged therefore that the cure for many of our social ills is not costly programs of rounding up and branding our chronic infections and certainly not any scheme for further socializing medicine. It is nutritious food and not pills that our people need. In the meantime, with the increasing acceptance by the farmer of the simple practices of soil conservation and the need of a war-time economy, the yield of the land has been greatly increased until we have in some food-stuffs enough to provide for all, provided the people of the United States got what we are producing. Many other items are still short.

Consequently now for over 15 years, I have been worrying about the capacity of our land to produce, whether our people can have a proper diet with a generous helping of fresh meat, milk and dairy products, animal fats, green and yellow fruit and vegetables, cereals in whole grain form—all of these fresh or unharmed by preserving, processing, or preparing. Or must we go to a cereal diet like the Oriental with all that such a diet implies, or might technicology really bring us the solution of an unlimited food supply? Might it be that some of the new non-fermenting yeasts that are being developed might make it possible to secure the bulk of the diet by growing such organisms on sawdust or other waste cellulose? Just what does the future hold in store for us? Will it be necessary to develop a whole new method of land use to support the increasing population of the earth?

I remember last year at this Conference, Paul Sears impressed deeply upon my mind that the 11,000 Indians who once owned and lived in Ohio were much more overcrowded with the system of land use than we are today with our 7,000,000 people. So, living room is a relative thing, dependent upon the culture of the people and the way they make use of their land.

Last year we were also told by Chester Davis that there are something over 2,000,000,000 people living on 4,000,000,000 acres of fertile land and that it takes with our present methods  $2\frac{1}{2}$  acres to support an individual. We left Camp Muskingum saddened because the world was already short one-half a billion acres of farm land to support its present population, but then we took heart for Dr. Bennett had told us at Tar Hallow the year before and Dr. Lowdermilk has told us again this year that the installation of the 12 simple conservation practices improved the yield of land so treated by more than 35 per cent. So combining what we have learned at the last three of these Conferences, it would seem that by stretching our resources about as far as we can with our present farming methods and then adding to this the widespread use of the soil conservation practices, the people of this earth would, if they tried, just about provide an adequate diet for themselves. I know of no figures on optimal diets—only adequate ones. But we already know from experience that for every unit the land is made to yield, the resulting vigor and vitality will increase the population two-fold.

We leave with the disturbing thought that the best we shall ever be able to do is to raise about half enough to feed our people unless we are able to turn to some technological plan, perhaps to yeasts instead of animals for our protein and so to raise the main portion of our living in vats. This is an intriguing idea that some day in our kitchens a tray of beans and cereals sprouting in mineral water and a vat of yeast growing on waste cellulose might furnish the food of us and farming would only be done for fiber to clothe ourselves and to furnish delicacies with which to garnish our food. Yet it does make more sense than the fanciful idea that some day we might get our food in pellets.

All this talk about a permanent peace is useless unless we can turn to some such technological advance. Here, again, we may just as readily stimulate our capacity to reproduce beyond our capacity to feed even with such a new culture.

Anyway, all of these things have been worrying me for a long time especially the pressing problem, "Can the United States in postwar days be expected to have the capacity left to produce and maintain production on an adequate amount of foodstuff?" I decided to ask the man who knew most about the capacity of our land to produce to come down and talk to the Fourth Conference—Dr. William Kraus of the Ohio Agricultural Experiment Station at Wooster, Ohio, a member of the Subcommittee on Food Supply and chairman of its Section on Milk of the Committee on Nutrition of the National Research Council. He gave a splendid summary of



the food situation—reserved, calculating, not pessimistic, but factual. It seems that it is possible for the United States to step up production of foodstuffs so that it will pretty well parallel our birth rate. As we come out of this war, we are told that shortly five per cent or less of the population will actually be engaged in producing the food for the rest of us. Even if this be too low a figure, the mass movement from farm to town and city will reduce our birth rate lower and lower. It is only on the farm and in the country village that the American can reproduce himself. Even the country birth rate goes down as rural people adopt the eating habits and modes of city folk. So with our industrialization and the resulting insecurity, down goes our birth rate. While ours goes down, other great powers go up. For example, if modern medicine and sanitation would be applied so as to cut down the death rate of Japan, China, Russia, or India to that of the United States, and anyone of these nations could just hold to the present birth rate, it could produce a population five times the number of people on this earth today in 100 years.

The industrialization of our country, with its two great world wars has enormously increased the per capita demand on our resources of copper, lead, iron, petroleum, cotton, and lumber, and will continue to do so; so population figures do not tell the whole story of the earth's destruction.

It is safe to say, therefore, that the United States of America stands today at the peak of her career as a leader in international affairs. Never again will she have the natural resources or the manpower to dominate.

In the meantime, those of us who believe that the health of the nation depends upon food and not upon medicines are glad to know that the capacity of the American farm to produce is adequate for an optimal diet for all of our people.

In listening to Dr. Kraus' paper our leasehold problems did not bother us as much as they do some. Only we wish that our leaders would stop shipping the vital elements from our soil to foreign lands to increase their health so that they can increase their population so that in the end they will be hungrier than when we began to give them our life's blood. For it would seem to me that such gifts, while helping now, only make future wars the more certain. I have always felt that the Hottentots should be taught to keep a cow and the people of the earth to feed themselves.

So it seems that we can borrow a lot of trouble and get very little satisfaction out of all these figures after all. To the realistic mind, it would not seem worth while to waste too

much time on the problems of world peace, for as long as our birth rate keeps well ahead of the food production rate, there will always be hungry people on this earth and hungry people are not peaceful. The hungry stomach knows no conscience. If, however, we are wise, it seems to me that we must recognize that there can be no peace and take a realistic position in regard to the international situation. This would call for a great navy and air fleet, with a fine standing army, a physical fitness program in the high schools that means business and is not just keyed to sell athletic equipment for those who belong to the proper trade organizations. No, not that, but a real program so that boys will graduate from high school ready to step into military training the day they arrive in camp. We have no time for C.C. Camps or a year of setting-up exercises in uniform. We must mean business if we are going to effectively protect ourselves in a hungry world. It should be stated that Dr. Krauss did not say any of these things, but that is what I learned by listening to him.

#### SOIL AND HEALTH

We closed the Sunday morning session with an outstanding paper by Dean C. R. Orton of the College of Agriculture of the University of West Virginia. It was presented in a reserved, dignified style by a friendly man and should have appealed to those of a scientific trend who have not been too impressed by the evangelism of us of the empiric cast who have told it many times to all who have attended these Conferences. It is an old story to them, that there is a direct relationship between the health of a people and the quality of their soil, but we wanted to be told from this other viewpoint and we congratulate ourselves that we had a master do it.

#### NUTRITION AND HEALTH

N. Phillip Norman, M.D., the well-known writer on nutrition and its application to clinical medicine and everyday living, made a definite contribution when he pointed out the great harm that is being done and has been done by the manner of processing our foods as well as by our food habits which are partly responsible for this processing and in turn are partly formed by the persuasion of the processors. Dr. Norman took physicians and nutritionists severely to task for not practicing what they preach. Certainly, today physicians do not as a group look healthy nor do nutritionists look properly nourished.

Dr. Norman pointed out that physicians are devoting their time to helping as best they can the sick recover, but this has nothing to do with health. Organic pathology is characterized by its irreversibility. No one who has been very sick can be completely restored. We physicians

have dedicated our lives to cobbling the human body, to repairing broken and worn out bodies so that they can be used a little longer. We have never kidded ourselves about our humanitarian service and that it deals with sickness not with health. I hope that we have kidded the public. In dealing with injury and acute illness we physicians have made wonderful advances. We can relieve pain, inspire confidence, and stop many infections so promptly that they do but little damage.

When you begin to consider, however, the so-called chronic degenerative diseases modern medicine offers little. These degenerative changes which are the results of incomplete combustion and choking the oxidative processes of the body with over-refined foodstuffs such as sugar and white flour.

Our clinicians of a rationalistic or scientific bent can measure, record, and report, but the degenerative process progresses as our blood pressure goes up, arteries harden, our coronaries plug, our kidneys wear out, our hearts grow tired and quit, our brains degenerate and we can do nothing about it to stop the degeneration but alleviate the pain and in an artful manner encourage our patient until death comes. Dr. Norman, who tries to apply to the preservation of human health that which is already known for the experimental animals of the laboratory, insists that a well-balanced diet restricted in its total calories but very rich in all of the food essentials would have prevented this premature ageing and death of so many splendid citizens just as they were about to make their greatest contributions to our society. Such a diet, he rightfully insisted, must consist of natural, properly preserved and prepared food. We have just witnessed our nutrition campaign carry the vitamin industry from a million dollars a year pharmaceutical business to a 250,000,000 dollar big business as a tribute to what advertising agencies and public relation counselors can do with the truth—or part of it.

We move now to the minerals and the amino-acids. These are only accessory to the main crime of devitalizing and over-refining our foodstuffs. Once before Dr. Norman had said, "Since when has it become safe for a people to delegate the control of its food culture to traders who assume no responsibility for the survival of the tribe? If this were found in a primitive tribe, 'the anthropologists' would then have no difficulty whatever in perceiving that the modes of these unfortunate savages were in a bad way."

All of us will agree with Dr. Norman, I am sure, that if our people had eaten the whole grains of cereals unspoiled by poor and prolonged storage untouched by dry kiln drying, unexploded, and not devitalized by prolonged heating or over-refining; if our people had eaten

green and yellow fruits and vegetables fresh from vine, tree, and garden; if they had eaten the meat of animals fed upon such nutrient forage and grain—especially the internal, or glandular organs, of such animals; and, finally, if our people had taken plenty of milk, butter, and if our people had drunk plentifully of milk which had not been too badly abused, with generous helping of cheese and genuine butter for their bread and cooking, they would have avoided most of these degenerative changes for in fact these changes represent the wearing out of the body from a lack of lubricants and the carbonization of the body through the oxidation of incomplete foodstuffs. These essential catalytic agents act as oxidative catalysts just as the lead compound does in your motor fuel. They insure that the fuel is completely burned up leaving no residue to corrode and destroy the body. These lubricants and catalytic agents are of course the vitamins which will appear naturally in our foodstuffs in optimal amount if our foods have been grown in soils which are rich in all of the minerals and organic materials that are necessary for strong healthy plants.

Yes, it is high time that the American people begin to think about health instead of disease and sickness; to prevent diseases by obtaining optimal health and maintaining it. Everyone seems intent upon fooling our people on this point by playing up sickness under the guise of health. We promote special causes of cancer, poliomyelitis, rheumatism, tuberculosis, by special weeks, stamp sales, march of dimes, presidential birthday parties and sale of seals. But who is telling the people about health and the happiness in just being fully and vitally alive, living a long, vigorous life, contributing one's own fair share to society up until the end? Who is telling our people about such things and how they can be obtained with what we already know? No, instead our leftist politicians fill the air about sickness and its toll and call it a health talk. Under the guise of health, they introduce into the Congress every year a program to foist upon our people a very inefficient and expensive scheme of indemnification in kind for sickness to be financed by the money which compulsion has extracted from the pockets of the worker.

Such measures which deal with sickness do not solve the fundamental problem of obtaining and keeping optimal health. No form of insurance, no spending of public or private money, no scheme of social planning will do the job, but the application of the principles which we of the Friends of the Land have been trying to put forth in these Annual Conferences on Conservation, Nutrition, Human Health, and Happiness will mean a long, joyful life, vigorous and productive to the end and with expectancy decades beyond that which we know today.



# The Treatment of Severe Acute Tonsillitis With and Without Sulfonamides

H. M. CLODFELTER, M.D.

HAVING noted the widespread use of sulfonamides in the treatment of sore throats it was decided to study groups of treated and untreated cases of severe acute tonsillitis with sulfonamides. The drugs used were sulfathiazole and sulfadiazine.

Only the severe cases of acute tonsillitis were selected, the type frequently referred to as "strep throats". Usually there was a membrane on the tonsil and in all cases the local reaction was severe as was the systemic. Many cases were cultured but the streptococci were not typed. The 400 cases were selected from more than 3,000 acute upper respiratory infections of such severity as to require hospitalization. Every effort was made to select the cases first because of the type of tonsillitis and the treatment or non-treatment was selected by lot. The cases were studied on a relatively alternate method in order to eliminate the difference in epidemiological factors. Forty-three cases selected for controls were given sulfonamides by other doctors. In these cases the drug was continued as ordered and the results studied.

All cases developing complications were excluded. Six patients developed otitis media. Five of these were receiving treatment and one was not. We were unable to study a single case of peritonsillar abscess untreated since these cases were already under intensive sulfonamide treatment when first seen by us and excluded from the series. There were no complications of note from the therapy.

The average temperature on admission of the 400 cases was 102.8° and a breakdown of the temperature of the treated and the untreated groups were the same. The average of the highest temperature reached by the control group was 103.4°. The average of the highest temperatures reached by the treated groups was not above the admission temperatures, and it was seldom that the temperature exceeded the admission reading in the treated cases.

The control group is made up of 168 cases. None of these received sulfonamide therapy. These patients received one APC capsule four times a day; throat gargles, if desired by the patient (not routine). All patients, both treated and un-

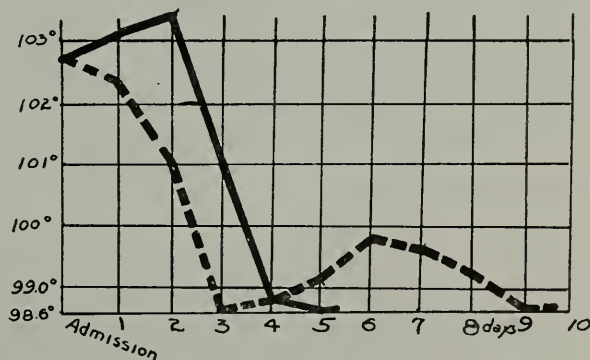
## *The Author.*

• Dr. Clodfelter, Columbus, Ohio, is a graduate of the University of Kansas School of Medicine, 1930; clinical instructor of medicine, Ohio State University College of Medicine. on military leave; now, Lt. Comdr., Med Corps, USNR, on active duty in the South Pacific.

treated, were kept in bed 24 hours a day except for head privileges; the diet was regular as desired by the patient; throat irrigations were used in the most severe cases irrespective of other treatment. No sedatives were to be given but five cases had two doses of sedative and 43 had one dose. No untoward effects were noted.

The average course of the control cases as represented by the heavy black line on the graph was as follows:

The admission temperature was 102.8°, gradually rising during the next 48 hours, reaching the high level of 103.4° on the second hospital day. The temperature dropped to 98.6° or lower on the fourth day and remained normal for 24 hours before discharge. The average number of days of hospitalization was 5.3 at which time the patient felt strong and well and rather resented the additional day required with a normal temperature before discharge.



Graph showing the temperature curves and hospital days of the sulfonamide and the non-sulfonamide treated cases.

The cases treated were divided into four groups according to the amount of sulfonamide used. Eighty-two cases had an initial dose of 2.0 grams followed by 1.0 gram every four hours day and night for at least four days, making a total dosage of 25.0 or more grams; 20 cases received 48.0 grams over a period of eight days with no change in the course of the disease in compari-

This article has been released for publication by the Division of Publications, Bureau of Medicine and Surgery, Navy Department. The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or as reflecting the views of the Navy Department or the Naval Service at large. Submitted April 2, 1945.

son with those treated four days only. The average course of these cases is shown on the graph with the broken line. There was a drop in the temperature during the first 24 hours and the patient seemed to feel better. The normal level was approached on the third day but on the fifth to seventh day there was a rise in the temperature with a slow drop to normal on the ninth day. The average number of days in the hospital was 9.7. These cases were likewise kept in until they had a full day of a normal temperature. These patients did not feel well, were unwilling to go back to duty and they did not look well. This factor might be explained by the "hospitalitis" developed by the long stay but it was my observation and conclusion that they did not feel well. (Several were kept in for five or six more days and by that time looked much better and were eager to be discharged. These are not included in the average hospital days.)

The next group of 50 cases were treated with 1.0 gram initial dose followed by 1.0 gram four times a day with an average of 16.0 grams as the total dosage. These averages coincided closely with the first group as to hospital days, secondary rise in temperature, and morbidity.

The group of 43 cases were those intended for controls but when the sulfonamides were ordered the treatment was continued as ordered. This was carried out because of the frequent statement that if sulfonamides were used correctly the results would be better. In this series the averages were similar to the other groups of treated cases. The dosage was from 12.0 to 36.0 grams over a period of from four to eight days. From the charts and from the patient no difference could be noted from the other sulfonamide treated cases.

Fifty-seven cases received 2.0 grams on admission and no further sulfadiazine or sulfathiazole used. At the end of the first day the average temperature was 102.6° at the end of the second day the average was 102.0°; on the third and fourth day the temperature coincided with the control series and the average number of hospital days was 5.3.

#### COMMENT

Forty-one cases of the 175 treated with large doses of sulfa drugs ran a similar course to the untreated cases and were discharged on the fifth or sixth day. One hundred and thirty-four cases had the secondary rise in temperature. The greatest number of discharges from the hospital in this group was on the tenth day and the average number of hospital days was 9.7.

Sulfathiazole and sulfadiazine were used in about an equal number of cases. We noted no appreciable difference in the two drugs.

#### CONCLUSIONS

The use of sulfonamides in the treatment of severe cases of acute tonsillitis results in a

prompt drop in the temperature with some relief from symptoms. But there is usually a secondary rise in temperature at the time untreated cases are being discharged. The number of hospital days is increased from 5.3 to 9.7 and added to this is the clinical observation that the patients did not feel as well on the tenth day as the untreated cases did on the fifth. No conclusions are drawn concerning the use of an initial dosage only since in view of the other findings it seems highly suggestive that the use of sulfonamides in the treatment of acute "strep" tonsillitis is not only of no benefit but actually detrimental to the welfare of the patient.

### Antibiotics in Onions and Garlic

Huddleson found that aqueous filtrates from many species of onions or garlic would inhibit growth of all three test organisms in dilutions as high as 1:160. The antibiotics in these filtrates can be heated to 60° C. for one hour without loss of bactericidal properties. The filtrates are inactivated, however, by heating to 100° C. for five minutes.

The active principle can be extracted from these filtrates by shaking them with chloroform. An impure, gum-like substance is obtained by evaporating the chloroform (partial vacuum). The active principle can be extracted from this initial product by its solubility in alcohol, the alcohol-insoluble fraction being inert. On evaporating the alcohol 150 mg. of a semi-purified antibiotic is obtained from one pound of onion bulbs, and approximately 500 mg. per pound from garlic.

The product thus obtained has many of the properties of penicillin. It inhibits the growth of *Staphylococcus aureus* and other gram-positive organisms in dilutions often as high as 1:600,000. It is relatively inactive against *E. coli* and other gram-negative bacteria. (The volatile *E. coli* inhibiting phytoncide of the Soviet bacteriologists is presumably lost during the process of isolation. The non-volatile quasi-penicillin is stable in water adjusted to pH 7.3, but slowly deteriorates in the presence of acid (pH above 7.5). The substance is not aldehyde nor a carbohydrate, its chemical nature otherwise being undetermined. Adequately controlled toxicity and therapeutic tests on experimental animals have not yet been reported.

Huddleson is of the opinion that the main practical value of non-volatile antibiotics of this type may not lie in their use as therapeutic agents, but as preventives of gastro-intestinal infections.—W. H. Manwaring, M.D., Stanford Univ.; Calif. & West. Med., Vol. 63, No. 1, July, 1945.



# Neurosurgical Treatment of Gynecologic Disorders

EDWARD W. SHANNON, M.D.

THE neurosurgical treatment of gynecologic disorders is a narrow field, which resolves itself chiefly into the control of intractable pain that can not be controlled by less radical measures.

Dysmenorrhea is probably the most common complaint with which a gynecologist has to deal. Only in primary dysmenorrhea, that is, dysmenorrhea in which there is no evidence of organic pathology, is neurosurgical treatment justified. There are as many theories as to the etiology of this disorder as there are methods of treatment.<sup>1, 2, 3</sup> As is so frequent in medicine when there are many forms of treatment for a disorder, few give good results. In order to have a rational basis for the surgical treatment of dysmenorrhea, it is necessary to understand the innervation of the pelvic organs.

"The sympathetic portion is derived from the preganglionic cells, which lie in the lowest thoracic and upper lumbar levels of the intermediolateral columns. These cells send their axons out over the lower white rami of the thoracolumbar outflow to lumbar and preaortic ganglia. Postganglionic neurons originate in the sympathetic trunks, as well as in the preaortic ganglia, to form a plexus descending along the abdominal aorta. At the level of the inferior mesenteric artery there are two small ganglia, and from them a plexus descends this artery to innervate the sigmoid and rectum. The remainder of the descending sympathetic fibers form the superior hypogastric plexus at the bifurcation of the aorta. This divides into the two hypogastric nerves which run into the hollow of the sacrum to join the inferior hypogastric plexus. Sensory fibers from the posterior root ganglia in the same segments of the cord run directly into the superior and inferior hypogastric plexus.

"The parasympathetic supply originates in the preganglionic neuron cells, which lie in the lateral portion of the anterior horns of the sacral cord. The axons run out over the 2nd, 3rd, and 4th sacral anterior roots and sacral nerves, to emerge from the sacral foramina in the hollow of the sacrum. Their rami, the nerve erigentes, passes through the inferior hypogastric plexus. A number of ascending fibers go to the descending colon via the inferior mesenteric plexus."<sup>4</sup>

Fibers from both the inferior and superior hypogastric plexus form plexuses in the broad ligaments, which are known as Frankenhäuser's plexuses. It is from Frankenhäuser's plexus

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that the innervation of the uterus is derived. The nerve supply of the uterus differs from that of the bladder; the greater part of its visceral afferent fibers go through the superior hypogastric plexus. Fibers from the intermesenteric and renal plexuses go by way of ovarian arteries to supply the ovaries and fallopian tubes. The vagina is innervated by fibers from the anterior portion of the inferior hypogastric plexus and a few sacral root filaments.

The sympathetic fibers carry visceral afferent sensory fibers, supply vasoconstriction and inhibition of the musculature of the sigmoid, rectum, and bladder, and cause ejaculation and contraction of the involuntary sphincters of the bladder. The parasympathetic fibers exert an antagonistic effect and cause vasodilatation and release of the corresponding sphincters.

## PRESACRAL NEURECTOMY

The selection of suitable candidates for presacral neurectomy is important, and only those in whom pain is intractable and who have failed to respond to conservative treatment should be advised to have the operation. The gynecologist should be as certain as possible that the pain originates in the uterus and not the ovaries, tubes, or bladder, because presacral neurectomy relieves only uterine pain.

The neurosurgical treatment of dysmenorrhea is not new and was first advocated by Jaboula in 1899, who suggested interrupting the pelvic nerves through a perineal incision for dysmenorrhea and pelvic malignancy. Twenty-six years later Lariche advocated a periarterial sympathectomy of the internal iliac arteries for the same condition. Cotte<sup>5</sup> in 1925 advocated resection of the superior hypogastric plexus, which is now the operation of choice.

Flothow<sup>6</sup> described a test whereby suitable candidates for presacral neurectomy could be selected. A bilateral injection of 2 per cent novocaine is made in the region of the second, the third, and the fourth lumbar ganglion. If this injection relieves the pain, then surgery is ad-

vised. However, very few men can carry out this test.

The operation is performed through either a low midline subumbilical or Pfannenstiel incision. The patient is placed in the Trendelenburg position before the peritoneum is opened. The small intestines and colon are then packed upward toward the diaphragm and the retrosigmoid colon retracted to the left. The peritoneum overlying the bifurcation of the aorta is picked up and a vertical incision approximately 10 cm. long made in it. The superior hypogastric plexus lies in the triangle made by the bifurcation of the aorta, and all nerve fibers in this area should be carefully dissected out and sectioned. It is important to go down low enough to section the branches from the fourth lumbar ganglia, which run under the common iliac arteries. However, the dissection should not be carried to the inferior hypogastric plexus, because the normal

obtained 100 per cent relief from pain, and the other received 75 per cent relief.

The results of other reported series<sup>3,11,12</sup> are favorable, and the percentage of good results varies from 75 to 100 per cent. Certain surgeons, however, such as Jones,<sup>13</sup> believe the operation is of little value.

Postoperatively a high percentage of these patients have some bleeding, particularly if the operation is performed soon after a menstrual period. This is not to be confused with normal menstruation, and it is thought to be secondary to hyperemia of the uterus after removal of vasoconstrictures of the uterus.<sup>12</sup> Urinary complications are no more common than routinely encountered in laparotomies. Rarely stress incontinence may develop after the operation.

Pregnancy and normal labor are not disturbed by this operation.<sup>7,9</sup> Meigs reported, however, that intercourse may be interfered with, since only one of his five married patients had normal orgasm. Because the series is small, it is questionable if this is a significant percentage. Meigs also stated that in private practice only about 50 per cent of women have satisfactory intercourse. Other reports made no mention of this complication.

In the management of extensive carcinoma of the cervix, gynecologists are all too familiar with the severe pain and footdrop resulting from extension of the neoplasm by way of the broad ligaments to involve the lumbosacral plexus. The use of cobra venom to control intractable pain is rarely successful, but is worth a trial since there are no outward reactions to it. Presacral neurectomy has also been advocated for pelvic malignancy,<sup>14</sup> but most men believe that the denervation is not sufficiently extensive in this operation, and even though the pain may be relieved immediately, pain recurs with extension of the primary process.<sup>4</sup>

#### CORDOTOMY

In my opinion, cordotomy is the operation of choice and should be carried out as soon as the diagnosis of intractable pain secondary to an inoperable malignancy is made. Spiller in 1911 suggested section of the anteriolateral columns for the relief of intractable pain in malignancy, and this was successfully carried out by Martin the next year. It was the careful correlation between pathologic findings and clinical symptomatology that led Spiller to suggest this operation. In 1904 he had a patient at the Philadelphia General Hospital who had complete loss of pain and temperature sensation in his lower extremities with preservation of normal tactile sensation. A year later at postmortem examination a solitary tubercle was found in the right lateral spinothalamic tract and at a higher level on the left side the same tract was invaded by another solitary tubercle.<sup>15</sup> This operation, for reasons

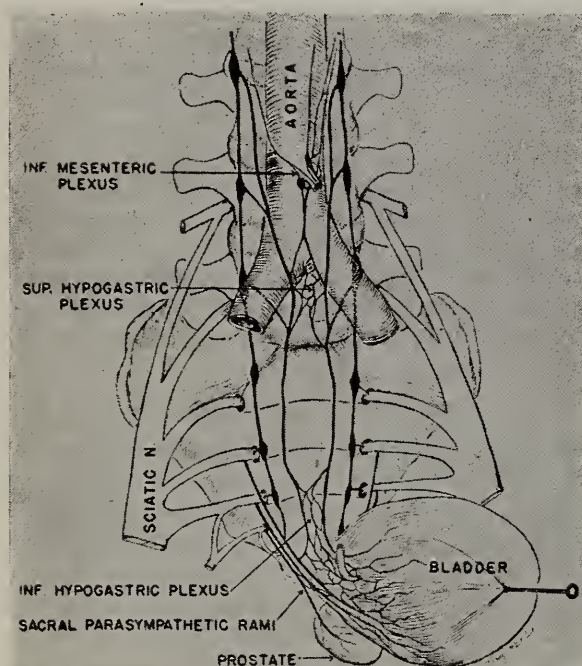


Diagram showing superior hypogastric plexus. (Courtesy White, J. C., and Smithwick, R. H.: *The Autonomic Nervous System*, New York: Macmillan Co., 1941.)

defecating mechanism may be interfered with. The pelvic organs should then be inspected, and any pathologic condition should be corrected.<sup>7,8</sup>

It is difficult to evaluate the results of presacral neurectomy alone, because it is the general practice to combine this procedure with the correction of any pelvic pathology which may be found. Meigs,<sup>9</sup> however, reported twenty cases in which presacral neurectomy alone was performed. Fifteen of the twenty patients had complete relief of pain, two had partial relief, and the other three were complete failures. In Counseller and Craig's<sup>10</sup> series of fourteen cases, six had presacral neurectomy alone. Five patients



unknown to me, has never been widely accepted in this region, although if properly performed, it gives complete and permanent relief of all pain.

It is not necessary to give the details of this operation. A laminectomy in the upper dorsal region is carried out, and the lateral spinothalamic tracts are then sectioned. It is usually necessary and wise to perform a bilateral cordotomy in pelvic malignancies, even though the pain is unilateral, because the other side frequently becomes involved at a later date.

Postoperatively these patients may have some weakness in their legs, but this almost always clears up. Rarely there may be some residual paralysis. The most common complication is urinary retention with the development of an overflow bladder. This is more apt to occur when a bilateral cordotomy is performed in one stage than when a unilateral cordotomy or a two-stage bilateral cordotomy is performed. The mechanism of this incontinence is not known. It must be realized, however, that many of these patients frequently have some actual or impending bladder disturbances preoperatively.

Subarachnoid alcohol injection for control of intractable pain may be of some value in those whose life expectancy is very short and who are too ill to have a cordotomy.<sup>16</sup> Most men have abandoned this procedure because sphincteric disturbances are almost certain to occur if a good block is obtained.

Although epilepsy is not a gynecologic disorder, the onset of seizures at the time of puberty suggests some relation between this malady and sexual function. In women the attacks may be more frequent in association with the menses. This necessitates an increase in anticonvulsive therapy and restriction of fluids for a few days before onset of the period in an attempt to reduce premenstrual edema, which may precipitate an attack.<sup>17</sup>

Babstisti<sup>18</sup> in 1938 reported that epilepsy has no appreciable effect on either the course or termination of pregnancy. When convulsive seizures develop during pregnancy, it is important to differentiate eclamptic convulsions and idiopathic epilepsy. This may be done by electroencephalography as well as by a careful history. Also in eclampsia the postconvulsive coma is more persistent, the blood pressure is elevated, edema may be present, and there are urinary changes.

#### SUMMARY

Neurosurgery enters the field of gynecology in the treatment of intractable pain associated with primary dysmenorrhea or pelvic malignancy. The results of presacral neurectomy in the treatment of dysmenorrhea have been favorable. Cordotomy is the operation of choice in the treatment of intractable pain caused by pelvic malignancy and, if properly performed, provides permanent and

complete relief. Subarachnoid injection of alcohol has a limited use when cordotomy is contraindicated because of short life expectancy.

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#### Fall Refresher Course

The University of Illinois College of Medicine announces its sixth semi-annual Refresher Course in Laryngology, Rhinology and Otology, September 24 through September 29, 1945, at the College, in Chicago. The course is intensive and largely didactic, but some clinical instruction is also provided. It is especially suited to specialists unable to devote a longer period for advanced instruction and to others seeking a comprehensive review of the field of otorhinolaryngology. The number of registrants will be limited. It is therefore desirable to apply for registration immediately. The fee is \$50. When applying, give full details as to school and year of graduation, postgraduate training, college degrees, etc. Write to Dr. A. R. Hollender, Chairman, Refresher Course Committee, Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.



# Acute Necrotizing Angiitis Due to Hypersensitivity Following Sulfonamide Therapy

ROBERT T. THOMPSON, M.D., and PEARL ZEEK, M.D.\*

ONE of the uncommon toxic complications of sulfonamide therapy, which has been reported by Rich,<sup>1</sup> is the occurrence of a necrotizing panarteritis. The following case presented such lesions at autopsy.

**Case 24604—History:** A 79 year old white male was admitted to the Cincinnati General Hospital on October 22, 1944. He was acutely ill and stuporous so the history was obtained from a daughter. The patient had been in fairly good health until 10 days before admission when he developed an upper respiratory infection followed shortly by chills, fever and cough productive of yellowish-gray sputum. The patient was given an unidentified sulfonamide drug for several days, starting 7 days before admission, but this was discontinued because the patient developed a severe headache. The patient improved until 2 days before admission when chills and fever recurred, accompanied by cough and rusty sputum. A sulfonamide drug was given again by his own physician but was discontinued after 2 or 3 doses because of recurrence of headache accompanied by vomiting. In the two days prior to admission the patient vomited frequently, being unable to retain anything taken by mouth. He complained of pain in the knees, and a rash on his hands was noticed one day before admission.

The past history revealed fractures of the 6th, 7th, and 8th ribs on the left with pneumothorax and subcutaneous emphysema following a fall in 1934. Complicating this injury was a left corneal ulcer and left endophthalmitis which required enucleation of the left eyeball. His blood Kahn was three plus on this admission. The patient's health had been good from 1934 until the present illness.

**Physical Examination:** Temperature 104°; pulse 120; respiration 48; blood pressure 100/75. The patient was a slender, elderly white man who was acutely ill and responded incoherently only to painful stimuli. He was cyanotic and dyspneic, and was most comfortable in semi-Fowler position. There was no notable adenopathy.

There was a maculo-papular rash over the palmar surfaces of the hands and a purpuric rash over the lower tibiae. The mouth was dry and edentulous, the tongue reddened and smooth, and the pharynx was reddened slightly. The left eye had been enucleated; the right eye showed reddening and swelling of the lids and conjunctivae. The trachea was in the midline. The chest was symmetrical at rest and at inspiration. Respiration was rapid and shallow. There was a depression deformity of the sternum. Breath sounds were impaired. Medium and fine rales were heard throughout the chest. Tactile fremitus was the same everywhere. There was dullness to percussion over the lower portion of

the right side of the chest. The heart was not enlarged to physical examination, the heart sounds were distant, the rate was rapid and the rhythm was regular except for an occasional extra systole. No cardiac murmur was heard. The abdomen was distended and tympanitic. Peristalsis could not be heard. The prostate was not enlarged. The tendon reflexes were all diminished but present. The abdominal reflexes were not obtained and the plantar responses were flexor in type.

**Laboratory Data:** Initial blood examination showed: Hemoglobin 13; red blood cells 4,410,000; white blood cells 13,150 with 95 per cent polymorphonuclear leucocytes. No eosinophiles were noted. The leucocyte count rose to 23,000 on the second hospital day. Sputum smear showed numerous gram-positive diplococci. On culture the sputum showed non-hemolytic streptococcus; three cultures of sputum were negative for pneumococci.

The urine showed two-plus albumin and 10 to 15 leucocytes per high power field. A catheterized specimen on the day of death showed many red blood cells, 15 to 20 leucocytes per high power field and a trace of albumin. Of five urine specimens examined, an occasional cellular cast was found in only one specimen. The patient was involuntary so that urine output could not be measured accurately. Urine output between 400 and 600 cc. daily was recorded from the third to the sixth hospital day. Specific gravity varied between 1.010 and 1.015. The stools were not remarkable.

The blood urea nitrogen was 33 mgms. per cent on admission and rose to 85 mgms. on the third hospital day. It was 95 mgms. per cent on the sixth day and 85 mgms. per cent on the eighth day shortly before death. The highest free sulfamerazine blood level was 12.5 mgms. 8 hours after the initial dose of 3 grams intravenously and one gram orally. Subsequent free sulfamerazine whole blood levels were 11.5 mgms. on the first hospital day and 9.3 mgms. on the second and third hospital days. The CO<sub>2</sub> combining power was 40 volumes per cent on the seventh day and rose following oral and intravenous sodium bicarbonate to 48 volumes per cent on the eighth day shortly before death.

A six foot roentgenogram of the chest taken on admission showed bronchopneumonia of the right lung, calcification of the aortic knob, prominence of the pulmonary arteries and pulmonary emphysema. Electrocardiogram showed auricular and ventricular premature contractions and evidence of myocardial damage.

**Course in Hospital:** Evidence of sulfonamide toxicity was recognized on admission. Since the patient had pneumonia throughout the right lung and in the left lower lobe it was considered that some specific treatment was necessary in spite of this. It has been shown that sensitivity to one sulfonamide may not necessarily be crossed to another sulfonamide.<sup>2</sup> Therefore sulfamerazine was chosen for the treatment of this patient's pneumonia because it was deemed unlikely that

\*The authors represent respectively the Medical and Pathological Service of the Cincinnati General Hospital.

This is the twenty-fourth in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.



he had received this new drug prior to his admission to the hospital. At that time it was not available generally to the medical profession. No penicillin was available.

The patient showed definite improvement on the day after admission. His temperature fell from 104° to a maximum of 100.4° on the first hospital day and his abdominal distension subsided. However, his course was never satisfactory. He never became rational and on physical examination never showed resolution of pneumonia. A total of 16 grams of sulfamerazine was given during the first three hospital days but the drug was stopped when the blood urea nitrogen was found to be 85 mgms. per cent on the third hospital day. The daily maximum temperature ranged between 100° and 101° from the second to the sixth hospital days and between 101° and 102° on the seventh and eighth hospital days. Full doses of covitamic and nicotinic acid and thiamine and riboflavin were used. Continuous oxygen by nasal catheter was given from the time of admission and the patient was kept in semi-Fowler position. Therapy was of no avail and the pneumonia gradually spread to involve all five lobes of the lungs. Azotemia persisted and a mild acidosis developed. The patient died on the eighth hospital day.

**Clinical Impression:** Confluent bilateral bronchopneumonia, especially marked in the right and left lower lobes; chronic glomerulonephritis with terminal uremia probably caused by sulfonamide nephrosis.

**Necropsy:** performed by Dr. Louis Aaron 28 hours after death. The lungs weighed 875 and 860 gms., right and left respectively. They presented acute bronchitis and extensive lobular pneumonia, both grossly and microscopically. The kidneys were markedly swollen and weighed 510 gms. together. The capsules were thin and stretched tautly over the smooth, congested surfaces. On the cut surfaces the markings were indistinct and there was prominent pale streaking of both cortices and medullae. No evidence of sulfonamide urolithiasis was found either grossly or microscopically. The aorta and coronary arteries were markedly sclerotic, with calcified plaques and intimal erosions. There were a few well healed scars in the myocardium. The other viscera, including the brain, presented no noteworthy departure from normal at autopsy.

On microscopic examination the vascular system presented several different types of lesions. There was moderate syphilitic aortitis, and advanced atherosclerosis of the aorta and other large arteries, including the coronary arteries, and there was moderate generalized arteriolar sclerosis. The most interesting vascular lesion was a widespread necrotizing inflammatory lesion involving small arteries, and some veins, in the heart, spleen, kidneys and liver. In these viscera numerous small vessels were necrotic and infiltrated with various types of inflammatory cells with neutrophils being the most numerous.

In only a few small foci, usually near a point of branching, was the necrosis of the fibrinoid, deep pink, smudge-like type. In most vessels the necrotic portions stained pale pink mottled with the dust-like, nuclear debris of karyorrhexis. The necrosis seemed to have begun in the intima but had spread rapidly through the vessel walls. The necrosis apparently preceded the inflammatory reaction since the former was occasionally found without the latter. Occasional eosinophiles were seen but they were not numer-

ous. Fibroblasts were few in number and were only found intermingled with other inflammatory cells. In no lesion were they found radiating out into the adventitia from the edge of the media as is so commonly seen even in early lesions of periarteritis nodosa. Further study of the differences between these two conditions is in progress.

Although small arteries were most frequently involved, there were numerous foci of necrosis of parenchymal cells in the viscera, and in the center of each of these foci a necrotic capillary or venule usually could be found. Numerous foci of necrosis were seen in and near the periphery of the Malpighian corpuscles of the spleen. In the spleen and liver foci of necrosis were prominent also in the walls of large veins, particularly in the portal veins of medium sized triads. Both the type of necrosis and the inflammatory reaction in the portal veins appeared to be identical in morphology with that found in arteries elsewhere. The hepatic arteries were usually not involved.

In addition to the inflammation associated with foci of necrosis in and around vessels, there was focal interstitial myocarditis (with polymorphonuclear leukocytes, eosinophiles and histiocytes) and diffuse non-suppurative interstitial nephritis (with lymphocytes predominant). These lesions have been described by Rich<sup>1</sup> and others as being associated with hypersensitivity. Bands of histiocytes were looked for beneath endocardium and vascular endothelium, but this lesion of hypersensitivity, described by Clark and Kaplan,<sup>3</sup> was not found.

In this case the kidneys presented the most severe lesions. In addition to the vascular lesions, the foci of parenchymal necrosis and the interstitial inflammation described above, there was also necrotizing glomerulitis representing probably just another manifestation of vascular necrosis. Terminal uremic pericarditis was present.

#### DISCUSSION

The necrotizing vascular lesions found in this case are similar to those found by Rich in cases of 'serum sickness and, later, in cases of sulfonamide hypersensitivity. The interstitial inflammation in the heart and kidneys as well as the focal necrosis of parenchymal cells have been described by Rich and others as also being associated with hypersensitivity.

At the time this patient was treated penicillin was not available for this type of case. Since it now can be used it should be employed in cases which show toxic manifestations after the use of any sulfonamide.

#### SUMMARY

A case of necrotizing angitis due to hypersensitivity following sulfonamide therapy is presented, in which the vascular lesions in the kidneys led to uremia.

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# Tuberculosis: Classification and Definition of Reportable Cases

Adopted by Division of Tuberculosis, Ohio Department of Health

## REPORTABLE CASES DEFINED

### I. Pulmonary Tuberculosis:

#### (A) Primary:

(1) Active.—The patient has a positive tuberculin reaction. The X-ray shows evidence of parenchymal infiltration or enlargement of hilum nodes or both.

(2) Questionably Active.—The patient has a positive tuberculin reaction. The X-ray reveals the pulmonary lesion to be of indeterminate stability.

(B) Reinfection (specify stage).—Minimal, moderately advanced, far advanced:

(1) Active.

(2) Questionably Active.

(3) Inactive.

II. Acute pleurisy with effusion, in the absence of demonstrable parenchymal lesion, trauma, or other demonstrable causative factor is considered to be of tuberculous etiology.

III. Active non-pulmonary tuberculosis (specify location).

## NON-REPORTABLE CASES DEFINED

The following types of tuberculosis need not be reported:

I. Inactive primary tuberculosis. The patient usually has a positive tuberculin reaction and chest X-ray may show areas of (pulmonary) calcification in the parenchyma or hilum, or both.

II. Inactive non-pulmonary tuberculosis.

## A CLASSIFICATION AND DEFINITION OF REPORTABLE CASES

Tuberculosis control is dependent to a large extent on records. Records must be reliable and accurate. Toward this end, an attempt is being made to standardize the classification of tuberculosis for the State of Ohio.

Three classifications are necessary:

1. Type of disease.
2. Extent of disease.
3. Degree of activity.

### 1. Type of Disease

Primary Tuberculosis: Primary tuberculosis is a first infection with tubercle bacilli and renders the individual sensitive to tuberculin. It is usually benign, but occasionally it may progress and serious complications ensue.

Reinfection Tuberculosis: Of all persons who acquire a primary infection at some time, only a small percentage ever develops clinical disease. Following the period of the primary infection

and its more or less direct consequences, a latent period usually intervenes before chronic pulmonary tuberculosis develops. The latter is due to a reinfection with tubercle bacilli. The re-infecting bacilli are derived from exogenous or endogenous sources.

### 2. Extent of Pulmonary Lesions

#### (Stage) (National Tuberculosis Association Classification)

The National Tuberculosis Association has devised excellent criteria for classification of tuberculosis by extent of disease. This method is widely known and used.

Minimal Tuberculosis: Slight lesions without demonstrable excavation confined to a small part of one or both lungs. The total extent of the lesions, regardless of distribution, shall not exceed the equivalent of the volume of lung tissue which lies above the second chondrosternal junction and the spine of the fourth or body of the fifth thoracic vertebra on one side.

Moderately Advanced: One or both lungs may be involved, but the total extent of the lesions shall not exceed the following limits:

Slight disseminated lesions which may extend through not more than the volume of one lung, or the equivalent of this in both lungs.

Dense and confluent lesions which may extend through not more than the equivalent of one-third the volume of one lung.

Any gradation within the above limits.

Total diameter of cavities, if present, estimated not to exceed 4 cm.

Far Advanced: Lesions more extensive than Moderately Advanced.

\* \* \*

To provide information relative to the degree of activity of the pulmonary lesions, a further classification is necessary.

### 3. Degree of Activity

For cases which have been under medical supervision for a period of time, e.g., patients in the sanatorium, the classification devised by the National Tuberculosis Association is generally used.

Apparently Cured: Constitutional symptoms absent. Sputum, if any, must be found negative for tubercle bacilli, not only by concentration and microscopic examination, but also by culture or animal inoculation. In case there is no sputum, the fasting gastric contents should be obtained and similarly examined. Lesions sta-



tionary and apparently healed according to X-ray examination. These conditions shall have existed for a period of two years under ordinary conditions of life.

A considerable but undetermined percentage of apparently cured patients, particularly those who have fulfilled the above requirements not only for two, but for six years, may in regard to their survival expectancy (as to tuberculosis) reach normal standards.

**Arrested:** Constitutional symptoms absent. Sputum, if any, must be concentrated and found microscopically negative for tubercle bacilli. Lesions stationary and apparently healed according to X-ray examination; no evidence of pulmonary cavity. These conditions shall have existed for a period of six months, during the last two of which the patient has been taking one hour's walking exercise twice daily, or its equivalent.

**Apparently Arrested:** Constitutional symptoms absent. Sputum, if any, must be concentrated and found microscopically negative for tubercle bacilli. Lesions stationary and apparently healed according to X-ray examination; no evidence of pulmonary cavity. These conditions shall have existed for a period of three months, during the last two of which the patient has been taking one hour's walking exercise daily, or its equivalent.

**Quiescent:** No constitutional symptoms. Sputum, if any, may contain tubercle bacilli. Lesions stationary or retrogressive according to X-ray examination; cavity may be present. These conditions to have existed for at least two months during which time the patient has been ambulant.

**(Frankly) Active (Improved, Unimproved):** Symptoms unchanged, worse or less severe, but not completely abated. Lesions not completely healed or progressive according to X-ray examination. Sputum almost always contains tubercle bacilli.

**Dead.**

\* \* \*

The National Tuberculosis Association classification, however, is impractical as a working designation in dealing with newly diagnosed cases and cases with insufficient or limited observation.

#### DEGREE OF ACTIVITY OF THE LESION

(Working Classification Used in the State of Ohio)

**Active (Corresponding to N.T.A. Active and Quiescent):** Cases of tuberculosis in which the X-ray reveals the lesions to be definitely soft or ulcerative, or in which comparative films show recent evidence of progression or retrogression of the disease. The sputum, if any, may or may not contain tubercle bacilli. Signs and symptoms of tuberculosis may or may not be present.

**Questionably Active (Corresponds to N.T.A.**

**Quiescent):** Cases of tuberculosis in which the X-ray reveals the lesions to be of indeterminate stability, without ulceration, requiring further observation. Sputum, if any, must not contain tubercle bacilli. Physical signs of tuberculosis may or may not be evident. Symptoms are not present.

**Inactive (Corresponds to N.T.A. Apparently Cured, Apparently Arrested and Arrested):** Cases of tuberculosis in which the X-ray reveals the lesions to be stable, without ulceration and apparently healed. Sputum, if any, must be negative for tubercle bacilli. Physical signs of tuberculosis may or may not be evident. Symptoms are not present.

\* \* \*

#### MORBIDITY REPORTS

**Regulation 2.** (Diseases, disabilities and infestations to be reported.) The disease, disabilities and infestations herein named and classified as "Class A" are declared to be dangerous to the public health, are made notifiable, and the occurrence of cases or suspected cases in Ohio shall be reported as provided in the following regulations.

##### Class A

|                                                                  |                                                 |
|------------------------------------------------------------------|-------------------------------------------------|
| Actinomycosis                                                    | Meningococcus meningitis (cerebro-spinal fever) |
| Anthrax                                                          | Milk sickness                                   |
| Botulism                                                         | Mumps (infectious parotitis)                    |
| Chickenpox (varicella)                                           | Paratyphoid fever                               |
| Chancroid                                                        | Pellagra                                        |
| Cholera                                                          | Plague, bubonic, septicemic, pneumonic          |
| Dengue                                                           | Pneumonia, acute lobar                          |
| Diphtheria                                                       | Poliomyelitis                                   |
| Dysentery, amebic (amebiasis)                                    | Psittacosis                                     |
| Dysentery, bacillary                                             | Puerperal infection (puerperal septicemia)      |
| Encephalitis infectious (lethargic and nonlethargic)             | Rabies (in man)                                 |
| Epidemic diarrhea of the newborn                                 | Rocky Mountain spotted (or tick) fever          |
| Erysipelas                                                       | Scarlet fever (scarlatina)                      |
| Favus                                                            | Septic sore throat                              |
| Food infections and poisonings                                   | Smallpox (variola)                              |
| Foot and mouth disease (in man)                                  | Syphilis                                        |
| German measles (rubella)                                         | Tetanus                                         |
| Glanders                                                         | Trachoma                                        |
| Gonorrhea                                                        | Trichinosis                                     |
| Gonorrheal ophthalmia                                            | Tuberculosis, pulmonary                         |
| Hookworm disease (ancylostomiasis)                               | Tuberculosis, other than pulmonary              |
| Inflammation of the eyes of the newborn (ophthalmia neonatorum)  | Tularemia                                       |
| Influenza                                                        | Typhoid fever                                   |
| Leprosy                                                          | Typhus fever                                    |
| Lymphogranuloma venereum, granuloma inguinale, and climatic bubo | Undulant fever (brucellosis)                    |
| Malaria                                                          | Whooping cough (pertussis)                      |
| Measles (rubeola)                                                | Yaws (frambesia)                                |
|                                                                  | Yellow fever                                    |

**Regulation 3.** (Who shall report.) Every physician practicing in the State of Ohio shall

be primarily responsible for submitting the report of a case of notifiable disease, disability or infestation in any person attended by him.

Regulation 4. (Reports from dispensaries, clinics, hospitals, etc.) A physician attending patients at a dispensary, clinic, hospital, asylum, or other public, semi-public or private institution may in writing authorize the superintendent or other officer or person in charge to submit the reports of cases of notifiable diseases, disabilities, or infestations in persons attended by him at the dispensary, clinic, hospital, asylum or other public, semi-public or private institution, but under no other circumstances shall a physician be relieved of the primary responsibility of reporting cases of notifiable diseases, disabilities or infestations in persons attended by him.

Regulation 5. (Information to be given; time limit). Each report, if made by a physician, nurse, midwife or other person shall be submitted in writing to the health commissioner within whose jurisdiction such case occurs, within twelve hours after the existence of the case of notifiable disease, disability or infestation is known or reasonably suspected.

Regulation 7. (Health commissioner to forward reports on standard form.) It shall be the duty of each health commissioner to have filled in on standard report blanks and forwarded to the state department of health the information from all reports of suspected or recognized cases of notifiable diseases, disabilities or infestations from persons not required to submit reports in writing, provided such cases are actual cases of notifiable diseases, disabilities or infestations.

Regulation 9. (Time for forwarding reports.) On Monday of every week each health commissioner shall forward to the state department of health all reports of cases of notifiable diseases, disabilities and infestations received during preceding days, accurate records having been made from such reports and duplication of reports having been eliminated as far as possible.

Regulation 10. (Special reports.) Each health commissioner shall submit promptly to the state department of health such special reports on the prevalence and control of notifiable diseases as may be required by the state director of health.

Regulation 13. (Investigation of reported case.) Immediately upon receipt of a report of any disease in which restrictive or preventive measures are required by the district board of health or the state department of health, the health commissioner shall determine the source of infection, the number of exposures, and secure such other information as may be necessary to prevent the spread of the disease.

## KEEPING UP WITH MEDICINE

THE hard recumbent X-ray of the chest possesses special value in patients with abnormalities of the spine, the diaphragm, the lungs, the heart, the big vessels of the thorax and mediastinum.

\* \* \*

DO not forget that low blood pressure goes with almost every instance of allergy. Manage the allergy and don't attempt to treat the low blood pressure.

\* \* \*

LOEFFLER'S syndrome looks more and more like an allergic reaction. This triad of a transient and migratory pulmonary infiltration, paucity of symptoms and physical signs and a peripheral eosinophilia has now been described in creeping eruption of helminthiasis, in tuberculosis, in *Ascaris* infections, in trichinosis, in asthma, Malta fever, *Endamoeba histolytica* infections and in pollinosis.

\* \* \*

THE more one sees of deconestant for nasal medication, the less one thinks of them. Even if they will not prove irritating still on some occasions the patient does become allergic to them but more frequently the compensatory congestion which follows their normal action turns out to be the most troublesome part of the disorder.

\* \* \*

THE importance of adequate and well-balanced nutrition on maximum work production, mental and physical alertness, nervous equilibrium, and general health is becoming recognized.

\* \* \*

IT is well known that general undernourishment or a deficiency of some vital element of nutrition increases fatigue, and certainly it also increases susceptibility to infection. More recently in these war days, our industrial physicians have been finding that such nutritional deficiencies increase susceptibility to the toxic hazards of industry.

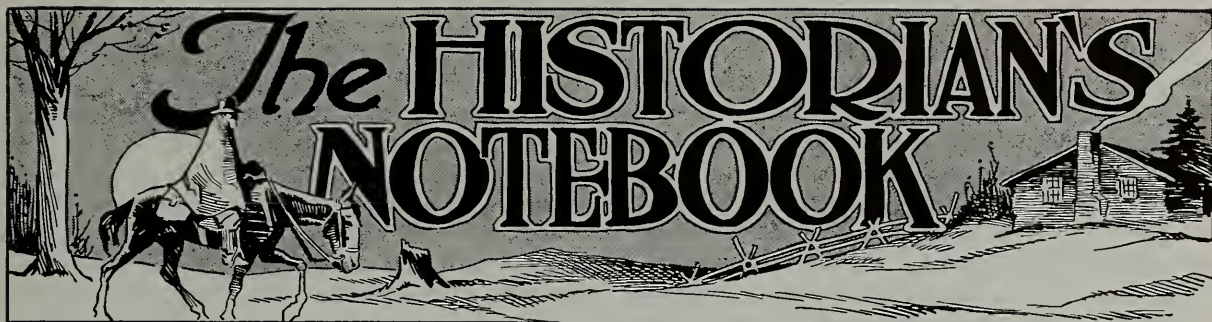
\* \* \*

AMERICAN young men are taller than their fathers. The average height is two-thirds of an inch greater than it was a generation ago.

\* \* \*

IT is interesting to read that 40 per cent of men who attempted suicide in 1942 and 1943 were motivated by illness and only 20 per cent by affairs of the heart, while with women 50 per cent were due to domestic difficulties and 20 per cent to illness and 10 per cent to love affairs. Strange world, isn't it? Yet there are those that think medicine is a science and not an art.—J. F.





*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## Ohio Women in Medicine—A Biographical Note

FRANCES HOLLINGSHEAD, M.D.

ELIZABETH CAMPBELL was born in the little town of Ripley, Ohio, on February 3, 1862. Her forebears were of Ohio's best stock; her great-grandfather, Thomas Kirker, was one of the first Governors of Ohio. Her Grandfather Leavitt's homestead, where her mother was brought up, stands high on a hilltop overlooking a broad sweep of the river and was well known as a station of the underground railway during the troublous years of the Civil War. Indeed, tradition has it that Eliza, herself, slept there one night. It commanded so fine a view that today the property belongs to the Ohio State Park System. The little town of Ripley, still much the same today, lies directly on the banks of the Ohio with some of its fine old homes standing on a bluff almost at the water's edge. Such surroundings offered a pleasant and happy background for the little girl's childhood.

Although she always loved her birthplace, Elizabeth Campbell was too restless, too eager to make broader contacts, to remain for very long in a small community. When quite young she came to Glendale to boarding school and then later studied and taught art for which she had definite ability. One of her dearest medical friends used to tease her by insisting that a fine artist had been spoiled to make a poor doctor. Gradually she became more and more interested in medicine and began by reading secretly in the office of a Ripley physician. Before long she decided to take up the study of medicine as her life work and despite much opposition from both her family and her friends she went to Ann Arbor to enter the University of Michigan. At Ann Arbor she worked especially with Victor Vaughn, who wanted her to remain after graduation and work in his labora-

### *The Author*

• Dr. Hollingshead, Cincinnati, is a graduate of Miami Medical College, Cincinnati, 1904; retired from active practice.

tory and with whom she kept in touch for years. After three years at Michigan, unforeseen responsibilities brought her back to Cincinnati where she graduated in 1895. She accepted an internship at Framingham, Massachusetts, and after completion of her term returned to Cincinnati to begin her long service, first as general practitioner and then as internist. Later she established a permanent home in the city and her family moved from the old home to join her.

She used to tell an amusing story of one of her early experiences. Invited to a luncheon at a time when she had but few patients and fearful that she might miss a call, she warned her maid to call her if she should be wanted. Much to her discomfiture, in the midst of luncheon her hostess's maid came in and whispered to her mistress who, with a bit of a smile, reported that Dr. Campbell's maid had called and said to tell the doctor that nobody wanted her. Blessed with a never failing sense of humor, the young physician laughed heartily and after a moment of embarrassment enjoyed the happening as much as any one at the table.

### DIPHTHERIA

One of Dr. Campbell's outstanding characteristics was her unusual ability as a diagnostician. She seldom made a slip but if there was any question she would immediately take steps to prove or disprove her point. This directness is clearly shown in the following two incidents.

Early in her active career, she had a puzzling case in a man, who, while he had an acutely sore throat without membrane, still seemed too ill to be suffering from tonsillitis. Although there were no classical symptoms, she suspected laryngeal diphtheria. She therefore gave a heavy dose of anti-toxin, the only serum obtainable at the time, and then insisted that a nurse should be installed at once. Still dissatisfied, she returned later in the morning to find her patient cyanosed and markedly dyspnoeic. She called the hospital for an intubation set, but the laryngologist was long in coming. In the midst of a very violent paroxysm she took a small scalpel from her bag, made a median incision in the trachea, pulled the tubing from one side of her stethoscope and after inserting it into the opening, breathed into the tube at regular intervals. The patient lived for some time but died just as the laryngologist arrived prepared to intubate.

That noon, while making her rounds at Christ Hospital, she heard that the report was being circulated that the man had not died of diphtheria at all as there had been no membrane to account for the symptoms. She returned to her office and called a younger physician requesting that she go, as soon as possible, to the patient's home, ask to be allowed to remove the larynx and make a series of cultures from the tract. When the young doctor arrived at the home, she found that the patient had already been embalmed with an extra strong formalin solution because of the nature of the disease. She persisted, however, removing larynx and trachea, still finding no membrane upon examination, but in due time securing pure diphtheria cultures.

This proved shortly to have been an unnecessary precaution, as the nurse who cared for the patient became infected and died, the cook in the family nearly died, and Dr. Campbell's office attendant picked it up from the doctor's telephone receiver. Despite the fact that they had all received an immunizing dose of anti-toxin at once, they all succumbed to the virulent infection. Moreover, Dr. Campbell not only developed a typical case herself, but was totally incapacitated for nine months and until the day of her death she carried a valvular lesion as a memento of the experience. Subsequently she went through many cardiac attacks, but she never allowed her handicap to interfere with her regular activities for a moment longer than was absolutely necessary and very few of her patients ever knew that she had such a lesion.

#### COMEDY OF ERROR

On another occasion she checked on a diagnosis in a very different fashion. There was, in her own home, a very nice maid who suddenly developed symptoms which were decidedly suggestive of a pregnancy. With the maid stoutly

denying any such possibility, the doctor made an examination and found a softened cervix but there also seemed to be a myomatous uterus, so she thought that probably both a fibroid and pregnancy were present. She took the woman to the hospital for examination by the surgeon on duty. The latter was quite sure that it was a simple case of fibroid uterus and said so. When he performed the operation, he found a mass in the body of the uterus and removed the entire organ. As he removed the tumor he held it up and with a broad smile said, "Here you are, Dr. Campbell, you see that I was correct." She only smiled and waited until he had almost closed the abdomen, then she walked over to the table where the specimen lay, picked up a knife and laid the uterine wall wide open. After glancing at the canal for a moment she said to the surgeon, "There are two of them, doctor. Thank you very much, I am going." As she left the room an interne exclaimed, "Gosh, there are twins and they are alive." The two little hearts, as if to do honor to the diagnosis, continued to beat for hours as they lay immersed in saline solution. The surgeon turned first quite white and then quite purple as he indulged in some very colorful expletives.

Elizabeth Campbell was all for fair play, but she demanded that a decision should be proven just before she would accept it. Furthermore when she believed that she was right she had no fear as to what the consequences might be. The comfort of the patient always came first with her and many a nurse was made aware of this fact if perchance she made an attempt to substitute an easier method for one which might cause more trouble to carry out but which the doctor had ordered.

Dr. Campbell's first civic project was the Visiting Nurse Association, which she was very largely instrumental in establishing. She was the first president of this, the first of the private-public health agencies in Cincinnati.

Dr. Campbell's interest in social hygiene dated back to the very early time when one spoke with bated breath of venereal disease and when it was the proper thing to faint during a quite mild and harmless lecture at the university or before a woman's club. She kept right on, however, despite criticism, speaking frequently and always maintaining that the subject should be discussed impersonally, without sentimentality but scientifically. Her efforts culminated in the organization of the local Social Hygiene Association in 1917, she serving as its first president. She always continued a lively interest in its development and progress, invariably urging its officers to broaden its scope. In 1942 Dr. Campbell was given the honorary life membership award of the National Social Hygiene Association.

It was quite natural that in continuity with



the development of this program, she should become especially interested in planned parenthood. She fought a good fight to establish the Cincinnati Committee on Maternal Health as an activity closely affiliated with and sponsored by the Academy of Medicine. Very shortly before her death she reaffirmed her sincere hope that there would always be, among the younger men and women in medicine, some who would be interested in serving on the executive committee of the organization so that the work should always be kept in close touch with the Academy of Medicine and its standards not only be maintained but raised as opportunity offered.

#### WOMEN IN MEDICINE

The position of women in the medical world was always a matter very close to her heart but she had no patience with the separation of women from men within the profession. She felt so keenly about this that for three consecutive years she organized a little group to go to the meetings of the American Medical Association to fight against the formation of a national woman's association. To the often uttered complaint that women were not properly represented on programs at national meetings through presentation of papers or as discussion leaders, her answer was always, "when you have something really worth while to say the men will listen". It always troubled her that after having asked for membership in the A.M.A. and having been granted the privilege, the women should want to cut themselves off again by forming a separate group. Finally she gave up the struggle after having stopped the movement several times, but she would never join the National Woman's Medical Association.

Though a firm believer in women's right to a dignified position in medicine on an equal footing with men she was always feminine in her mental attitude as in her appearance. She loved and respected many professional men but in the final analysis she was always essentially a feminine woman; it never occurred to her that to succeed in her chosen profession she had to become mannish.

Elizabeth Campbell gave much effort and greatly of her strength to Christ Hospital. For years, beside her ward work and that for her private patients, she took care of the nurses when they were ill and often times helped them in the solution of their personal problems. When, as time wore on, she could no longer carry the larger burden she still cared for a group of the graduates as private patients.

#### FIRST ON HOSPITAL STAFF

She was the first woman physician to be appointed a staff member in any Cincinnati hospital. She was made a member of Christ Hospital staff in 1902. During all of the years when

she served as a member of the staff, she kept up a very active interest in the hospital and had great faith in the value of its place in the community.

To describe Elizabeth's Campbell's vivid personality is an almost futile task, for while she seemed so simple most of the time, hers was really a very complex personality. Possessed of great gentleness and sweetness of manner she could, if occasion demanded, become very stern and imperious almost in an instant. Courageous and fearless but serene she faced the most difficult situations without flinching. With a deep but informal religious feeling she combined an artistic sensitivity. Despite all of these serious attributes she had an unusual ability to throw off all responsibility for the moment and to play as hard as she could work. She was a wonderful friend and many are those who were privileged to know her well enough to testify to this. She was a delightful companion, but the second that a patient really needed her she was ready to drop everything and work indefatigably to get results. She demanded much of her associates but she demanded much more of herself.

As the years passed and a number of serious illnesses and operations followed closely each upon the other, Dr. Campbell staged an amazing comeback each time and it seemed as though her often expressed wish to drop over in harness might come true. But such was not to be the case, for five long months she was unable to take up her work. During all of this trying period her mind was as alert as ever. Then, too, her courage and never-failing sense of humor did not lapse for a moment and at last the end came very quietly and sweetly in the early morning, on June the seventh. A few hours before she died one of her physicians said, as he turned away from her bedside for the last time, "Well, we should all have learned one thing from her and that is how to take a thing like this magnificently."

She was without doubt Cincinnati's leading woman physician and as the younger women come on in medicine they will have to go far to outstrip or even approach her influence in her chosen profession and in the community at large.

Mass surveys of industrial workers, students, and army inductees have demonstrated quite clearly their usefulness in discovering unsuspected tuberculosis, but one large reservoir of tuberculous infection has thus far been almost entirely overlooked—those patients admitted to our general hospitals. Only a few hospitals and clinics in the country have adopted a program of routine roentgenographic examination of all patients, regardless of the nature of their complaint.—Karl H. Pfuetze, M.D., Med. Dir. and Supt., Mineral Springs San., Cannon Falls, Minn.

# Proceedings of The Council

## Matters Relative to Indemnity Company Discussed at Aug. 19 Meeting; Plans for 1946 Annual Meeting Made; Radio Proposal Considered; War Developments Reviewed

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, August 19, 1945, with the following in attendance: President Schriver, President-Elect McNamee, Treasurer Mitchell; Councilors Messenger, Noble, Brindley, Dixon, Rutledge, Lincke, Swan, Micklethwaite and Harding; Dr. Forman, Editor of *The Journal*; Executive Secretary Nelson and Assistant Executive Secretary Saville.

The minutes of the last meeting of The Council, held on March 25, 1945, were approved, on motion by Dr. Dixon, seconded by Dr. Lincke, and carried.

A report on membership presented by the Executive Secretary showed that the total membership for the State Association as of August 18, 1945, was 6,829, of which 1,987 were military members; compared to a total membership of 6,878 on December 31, 1944.

On motion by Dr. Knoble, seconded by Dr. Micklethwaite, and carried, the Executive Secretary was authorized to accept dues for new members affiliating during the third and fourth quarters of the year at a prorated amount, namely, \$5.00 for the third quarter and \$3.00 for the fourth quarter.

The purchase of a new addressograph was authorized, on motion by Dr. Micklethwaite, seconded by Dr. Brindley, and carried.

### OHIO MEDICAL INDEMNITY, INC.

A detailed report on the sale of stock of Ohio Medical Indemnity, Inc., and the status of the organizational activities of the company, work of the Committee on Medical Service Plans, etc., was presented by President Schriver, the Executive Secretary, and Mr. Stichter, legal counsel for the committee. The report showed that the issue of preferred stock offered for sale had been oversubscribed by 351 shares and that approximately 600 physicians had purchased stock. President Schriver stated that he felt this was a remarkable showing, inasmuch as the sale of the stock had been conducted solely through the issuance of a letter to all members of the Association.

On motion by Dr. Dixon, seconded by Dr. Micklethwaite, and carried, President Schriver was authorized to vote the 5,000 shares of common stock purchased by the Ohio State Medical Association at the first stockholders' meeting scheduled to be held at 1:00 P.M. on August 19.

Following a lengthy discussion, a slate of nominees for the Board of Directors for Ohio Medical Indemnity, Inc., was approved, on motion by Dr. Harding, seconded by Dr. Brindley, and carried, and the President was instructed to cast the votes of the Association for such nominees at the stockholders' meeting.

On motion by Dr. Brindley, seconded by Dr. Rutledge, and carried, the work of the Committee on Medical Service Plans was approved and confirmed and the committee was commended for its splendid work, covering a period of 16 months, relative to the formation of Ohio Medical Indemnity, Inc., and the Executive Secretary was instructed to convey these sentiments to members of the committee.

### 1946 ANNUAL MEETING

Members of The Council expressed themselves as believing that plans should be initiated immediately for the holding of the 1946 Annual Meeting of the State Association, which will be observance of the 100th anniversary of the Association.

On motion by Dr. Noble, seconded by Dr. Micklethwaite, and carried, The Council authorized the holding of the 1946 Annual Meeting at the Neil House, Columbus, on May 7, 8 and 9.

### RADIO PROGRAMS

Dr. Schriver reported on a meeting of the presidents of 17 state medical societies held in Detroit on April 27 and 28, 1945, under the auspices of the Michigan State Medical Society, and discussed specifically a proposal emanating from that meeting that the various state societies underwrite an extensive program of radio broadcasts covering territory with a population of approximately 70,000,000 persons.

After discussion, on motion by Dr. Brindley, seconded by Dr. Swan, and carried, President Schriver was instructed to advise the committee planning the radio setup that the Ohio State Medical Association would participate to the extent of expending \$4,000, providing the final setup meets with the approval of The Council.

### LEGISLATIVE MATTERS

Dr. Schriver also reported on the request of the Michigan State Medical Society that various state medical societies submit recommendations relative to Federal health and medical legislation to the Michigan Society so that it in turn could transmit such recommendations to the Council on



Medical Service and Public Relations of the American Medical Association.

The Council expressed itself as believing that it was not a position at this time to submit any specific recommendations, but on motion by Dr. Brindley, seconded by Dr. Noble, and carried, The Council approved and endorsed the 14-point platform recently issued by the American Medical Association, expressing the opinion that this platform represented a progressive stand on the part of the medical profession and contained general principles and policies to govern the action of the medical profession on pending and future legislative proposals.

#### WAR DEVELOPMENTS AND DEMOBILIZATION

There was a general discussion on war developments, including the activities of the Procurement and Assignment Service, early release of medical officers, activities of the Veterans Administration, etc.

The Executive Secretary, reporting for Dr. Robert Conard, chairman of the Ohio Procurement and Assignment Committee, stated that since the surrender of Japan the status of the Procurement and Assignment Service was somewhat in doubt and that the activities of the Ohio committee were being held in suspense awaiting further instructions from Washington.

#### EARLY RELEASE OF DOCTORS ASKED

On motion by Dr. McNamee, seconded by Dr. Rutledge, and carried, The Council adopted the following statement relative to the early and prompt release of medical officers, and instructed the Executive Secretary to transmit a copy of the statement to the President of the United States, Secretaries of the War and Navy Departments, the Surgeons General of the Army and Navy, and to Ohio members of the Congress:

"It is the sincere hope of The Council of the Ohio State Medical Association that the policies and procedures relative to the discharge of medical officers, set forth in the recent statement of the Army War Department, will be subjected to a liberal interpretation by the War Department and will be liberalized from time to time as circumstances merit. Also, it is hoped that these policies and procedures will receive the sympathetic attention of commanding officers whose advice undoubtedly will be sought in determining which medical officers can be separated from the service and how soon.

"Moreover, The Council of this Association urges the Navy Department and the Surgeon General of the Navy to initiate similar steps looking toward the early release of medical officers of the Navy who entered that service from civilian life.

"We realize that it took many months to mobilize the medical services of the Army and Navy for the great conflict which has just ended and that the release of the many thousands of physicians who have written such a glorious chapter in the history of American Medicine through

their military achievements can not be accomplished overnight.

"We are aware of the fact that it is the obligation of the nation and the medical profession to provide highly specialized medical services for disabled soldiers and sailors now being hospitalized. We know that adequate medical care must be provided for the men who will comprise the various forces of occupation. We realize that serious transportation difficulties are involved in the demobilization of our troops.

"Nevertheless, no physician should be held in military service a day longer than the interest of the nation requires. Every possible effort should be exerted to expedite complete demobilization of the thousands of doctors who volunteered their services during the war emergency.

"Those of us who reside and practice on the home front are keenly aware of the need for physicians to maintain adequate medical and health services for the civilian population. This problem is becoming increasingly acute in many communities. The present situation in some areas is desperate.

"Actually, the only way this problem can be solved is through the early release of large numbers of medical officers so they may return to their home communities or relocate in districts where there is a serious shortage of medical personnel.

"The civilian population has been patient and cooperative, realizing that the men and women in the military forces were entitled to the best of medical care and that medical personnel in the services had to be adequate for all conceivable emergencies.

"Physicians who have remained on the home front, many of them of the upper age brackets, have worked long and diligently in serving civilians. Many of these doctors are at the breaking point physically. Good health services can not be maintained for long under these circumstances.

"Many of the physicians now in the services have been in uniform for four or five years. The question of their future must be given serious consideration, as well as their morale and economic security.

"For these reasons, it is imperative in the opinion of The Council of the Ohio State Medical Association that the military authorities release as promptly as possible every doctor whose services and be spared. The welfare of the nation demands that this be done. The thousands of medical officers who have served the nation so ably during the dark days of the past four years are deserving of such action. We are confident that these sentiments will be concurred in by those in authority who have been in a better position than others to witness and comprehend the remarkable achievements recorded by members of the medical profession while members of the Army and Navy Medical Corps."

#### MISCELLANEOUS ACTIONS

No action was taken on certain matters relative to the activities of the Veterans Administration, but the Committee on Public Relations and Economics was instructed to follow such matters carefully and report to The Council at the appropriate time.

A request of State Director of Health Heering, for suggestions of physicians to serve on an ad-

### Centennial Anniversary Meeting of State Association Planned For May 7, 8 and 9, 1946, at Neil House

**B**Y action of The Council on August 19, planning for the 1946 Annual Meeting of the Ohio State Medical Association has been started.

Unless unforeseen conditions arise, the 1946 Annual Meeting will be held at the Neil House, Columbus, May 7, 8 and 9.

This will be the Centennial Anniversary of the Ohio State Medical Association, it having been founded on May 14, 1846, at the Neil House, Columbus.

A meeting of the Committee on Scientific Work will be held soon to make preliminary plans for the 1946 program.

A brochure regarding the Technical Exhibit will be mailed about October 1 to all prospective exhibitors.

visory committee to the Child Hygiene Division, was considered. On motion by Dr. Lincke, seconded by Dr. Mitchell, and carried, President Schriver was authorized to confer with Dr. Heering on this matter and to make suggestions to him on behalf of the Ohio State Medical Association.

Amendments to the constitution and by-laws of the Columbus Academy of Medicine recently adopted by the Academy were reviewed and approved, on motion by Dr. Noble, seconded by Dr. Harding, and carried.

On motion by Dr. Dixon, seconded by Dr. Micklethwaite, and carried, The Council expressed its appreciation to the Ohio Industrial Commission for its favorable action on most of the recommendations made by the Ohio State Medical Association with respect to changes in the medical and surgical fee schedule and for its cooperation during the negotiations on this matter between representatives of the Association and representatives of the Commission.

The Council then adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,  
*Executive Secretary.*

### Fees Allowed Doctors for Affidavits Can Be Paid by State Treasury

Fees payable by rule of the Industrial Commission to physicians for affidavits furnished by them upon request of the Commission and containing information to be used as a basis for adjudication of claims constitute disbursements which are legally and properly payable out of the State Treasury, under the provisions of Sections 1465-42 and 1465-102, General Code, and are not such disbursements as are legally and properly payable as compensation or benefits out of the State Insurance Fund, Attorney General Hugh Jenkins has advised the Ohio Industrial Commission. (Opinion 356.) Provision for paying physicians a fee of \$3.00 for furnishing such affidavits was incorporated in the revised medical fee schedule, effective May 1, 1945.

### New Chief of Industrial Hygiene Division Is Appointed

Dr. Charles M. McGill of the U. S. Public Health Service is the new Chief of Industrial Hygiene, State Department of Health.

Dr. McGill received a B.S. degree from the University of Washington, Seattle, in 1930, and graduated at the Vanderbilt University School of Medicine, Nashville, in 1935. Following an internship at the U. S. Marine Hospital, Seattle, and a residency in medicine at the U. S. Marine Hospital, Cleveland, he was commissioned in the U. S. Public Health Service in 1936.

His duties since that time have included: U. S. Quarantine Stations, six months; U. S. Coast Guard, Atlantic patrols, six months; research in the therapy of human malaria, Georgia and South Carolina, two years, and local health work in Georgia, two years; hospital training, eye, ear, nose and throat, Boston, one year; industrial health work, Southern United States, one year; assistant chief health consultant, U. S. Maritime Commission, Gulf Coast Region, two years.

In July, 1945, Dr. McGill completed a post-graduate course at the Harvard School of Public Health, and received the degree of M.P.H. in Industrial Hygiene. He succeeds Dr. Christopher Leggo, who resigned several months ago.

### Long, Expensive Claim Terminated

One of the most expensive occupational injury claims pending in the files of the Industrial Commission is now being closed, according to the O.I.C. Monitor. On April 28, 1924, a young woman, employed at a woolen mill in Lima, suffered head injuries when a shuttle flew off a machine. Her skull was fractured and a neurosis developed, making her a permanent total disability. She died on March 10, 1945. The case cost the State Insurance Fund, in addition to compensation payments, a total of \$41,896.14 for medical care, hospital and nursing service, with funeral expenses and a number of bills yet to be paid.



## Ohio Procurement and Assignment Activities Suspended By Chairman Conard, Pending Receipt of Advice From Washington As To Future Status of That Agency

**F**UTURE status of the Procurement and Assignment Service for Physicians in the light of the end of hostilities was in doubt as this issue of *The Journal* went to press.

Dr. Robert Conard, Wilmington, Ohio chairman of the Procurement and Assignment Service, had received no advice from the Directing Board of the Procurement and Assignment Service, War Manpower Commission, Washington, concerning the future responsibilities and functions of the Ohio committee, if any.

As soon as instructions and information are received from Washington, an effort will be made to give wide publicity to them.

There is considerable confusion relative to the part, if any, which the Procurement and Assignment Service will take from now on in the matter of recommending the release of medical officers from the armed forces.

Since last Fall, the Procurement and Assignment Service has served in an advisory capacity to the War Department on matters of separation of Army Medical officers, recommending the discharge of certain medical officers so they could return to their former homes in event an acute shortage of physicians existed in such areas.

However, in the August 11 issue of *The Journal of the American Medical Association* there appeared a statement from the Office of the Surgeon General of the Army, establishing a point system and certain basic principles governing the release of "surplus" medical officers. There was no intimation in that statement that the Procurement and Assignment Service would be called upon to make recommendations. During the past few weeks, a number of Ohio medical officers have been discharged without any consultation on the part of the War Department with the Ohio chairman.

The surrender of Japan has caused additional confusion, inasmuch as the Surgeon General's statement publicized on August 11 was made prior to the cessation of fighting. It is believed that this new development will require the Surgeon General to revise the present point system and other procedures on the matter of separations from the service.

Until definite instructions have been received from Washington, clarifying these matters, the Ohio Procurement and Assignment Service will discontinue making recommendations on the discharge of medical officers, according to Dr. Conard. Pending cases will be kept on file and appropriate action taken if the activities of the Procurement and Assignment Service are continued and they provide for the making of recommendations on civilian needs.

Moreover, Dr. Conard announced that he has suspended all other activities which have been carried on by the Ohio Procurement and Assignment Service, pending receipt of instructions from Washington.

Medical officers separated from the service who may be looking for locations may obtain factual and statistical data from the Headquarters Office of the Ohio State Medical Association, 79 East State Street, Columbus 15.

In general, the State Association will not make recommendations but will supply as complete information as possible on urban and rural areas to assist the medical officer in making a decision as to opportunities for establishing a practice.

However, specific listings will be made, if possible, of communities without a physician, areas from which no physician entered military service and districts where there is good reason for believing that the former practitioner plans to relocate elsewhere.

# Stockholders of Ohio Medical Indemnity, Inc., Elect 21 Directors; Application for License To Do Business Will Be Made Shortly After Meeting of Board

**M**EMBERS of the Board of Directors were elected and a Code of Regulations adopted at the first meeting of the stockholders of Ohio Medical Indemnity, Inc., held in Columbus on August 19.

Those elected to serve on the Board of Directors of the company which has been formed through the initiative of the Ohio State Medical Association and eight of the Blue Cross Hospital Service Associations of Ohio to provide cash indemnity against medical, surgical and obstetrical expenses were:

## PERSONNEL OF BOARD

L. H. Schriver, M.D., Cincinnati, President, Ohio State Medical Association.

Robert C. Rothenberg, M.D., Cincinnati, chairman, Committee on Medical Service Plans, Ohio State Medical Association.

R. K. Finley, M.D., Dayton, member, Committee on Medical Service Plans, Ohio State Medical Association.

Carll S. Mundy, M. D., Toledo, member, Committee on Medical Service Plans, Ohio State Medical Association, and member of the board, Hospital Service Association of Toledo.

Edgar P. McNamee, M.D., Cleveland, President-Elect, Ohio State Medical Association.

William M. Skipp, M.D., Youngstown, member, Committee on Medical Service Plans, and a former President, Ohio State Medical Association.

C. C. Sherburne, M.D., Columbus, immediate Past-President, Ohio State Medical Association.

Jonathan Forman, M.D., Columbus, member, Committee on Medical Service Plans, Ohio State Medical Association, and Editor, Ohio State Medical Journal.

Carl R. Steinke, M.D., Akron, Ohio Delegate to the American Medical Association.

J. Craig Bowman, M.D., Upper Sandusky, former member, Committee on Public Relations and Economics, Ohio State Medical Association, and chairman, Section on General Practice of Medicine, American Medical Association.

Carl A. Lincke, M.D., Carrollton, member, The Council, Ohio State Medical Association.

Barney J. Hein, M.D., Toledo, chairman, Committee on Public Relations and Economics, and former President, Ohio State Medical Association.

Charles L. Ferguson, M.D., Portsmouth, president, Portsmouth Hospital Service Assn., and former president, Hempstead Academy of Medicine.

Mr. Harold Vincent, Akron, assistant superintendent of schools, and member of board, Akron Hospital Service.

Judge Henry W. Harter, Canton, member of board, Hospital Service, Inc., of Stark Co., Canton.

Mr. L. F. Reinartz, Middletown, executive of American Rolling Mills, and member of board, Hospital Care Corporation, Cincinnati.

Mr. C. H. Neville, Lima, attorney and president of board, Hospital Service, Inc., Lima.

Mr. Dave Endres, Youngstown, superintendent, Youngstown Hospital Association, and member of board, Associated Hospital Service, Inc., Youngstown.

Mr. E. C. Pohlman, Columbus, superintendent, Grant Hospital, and member of board, Central Hospital Service, Columbus.

The Most Reverend Karl J. Alter, D.D., Toledo, Bishop of the Toledo Diocese, Roman Catholic Church, and member of board, Hospital Service Association of Toledo.

Mr. Charles H. Mylander, Columbus, vice-president, Huntington National Bank, and member of Board of Trustees, White Cross Hospital.

## MEETING OF BOARD SCHEDULED

A meeting of the Board of Directors will be held in Columbus on September 5 for the purpose of electing officers, adopting an indemnity contract, establishing premium charges and transacting other important business.

It is anticipated that soon after the first meeting of the Board of Directors, application will be made to the Superintendent of Insurance for a certificate of authority to start business. As soon as the certificate of authority has been granted by the Superintendent of Insurance, the company will be ready to operate.

Enrollment of subscribers and many additional administrative activities will be handled for the company through the Blue Cross Hospital Service



Associations of Cincinnati, Columbus, Akron, Canton, Youngstown, Toledo, Lima and Portsmouth.

The home office of the company will be located in Columbus with full-time, experienced and trained personnel in charge.

#### STOCK ISSUE OVERSUBSCRIBED

The 2,000-share issue of preferred stock of Ohio Medical Indemnity, Inc., offered for sale on July 11 was oversubscribed by 351 shares. This made it necessary for the incorporators to limit the number of shares sold to any one individual and to authorize refunds totaling \$17,550. Approximately 600 physicians, representing 73 counties, purchased stock. Sale of the stock was conducted solely through the issuance of a letter to each member of the Ohio State Medical Association.

The company will start business with \$105,000 of capital funds, realized through the sale of the 2,000 shares of preferred stock to individuals and the purchase of 5,000 shares of \$1.00 par value common stock by the Ohio State Medical Association at \$7.00 per share which also provides the company with a surplus of \$30,000.

Policies governing the activities of Ohio Medical Indemnity, Inc., will now be decided by the stockholders and the duly elected Board of Directors. Work of the incorporators was ratified at the initial stockholders' meeting. Information assembled by the Committee on Medical Service Plans of the Ohio State Medical Association during the past 16-month period when plans for the company were laid and negotiations carried on with representatives of the Blue Cross plans, has been turned over to the Board of Directors, together with certain recommendations with respect to provisions of the indemnity contract, rates, etc.

#### Van Wert Druggist Appointed To Public Health Council

Howard A. Hines, Van Wert, has been named a member of the Ohio Public Health Council by Governor Frank J. Lausche, in accordance with H. B. 31, passed at the recent session of the General Assembly, adding a registered pharmacist to the Council.

A graduate of the Ohio State University College of Pharmacy in 1924, Hines has been in the drug business in Van Wert, where members of his family have been druggists for many years. He is a vice-president of the Northwest Ohio Pharmaceutical Association and a member of the Ohio State Pharmaceutical Association.

Other members of the Ohio Public Health Council are: Russel G. Means, M.D., Columbus, chairman; Wilmer Helmer, Cincinnati, vice-chairman; J. Howard Holmes, M.D., Toledo; L. F. Huffman, M.D., Cleveland; Samuel F. Ridings, D.D.S., Greenville, and Mrs. Lily Cooper, Findlay.

#### Openings for Physicians at Ohio Industrial Commission

There are approximately eight openings for physicians on the medical staff of the Ohio Industrial Commission, according to Dr. Robert André, chief of the Medical Section.

Physicians who may be interested in full-time work in the Medical Section of the Commission should get in touch with Dr. André at the Commission's offices, State Office Building, Front Street, Columbus.

The salaries paid depend on qualifications and assignment, the minimum being \$3,200 per annum.

#### Department of Clinical Biochemistry Created at Western Reserve

Creation of a new department of Clinical Biochemistry in the Western Reserve School of Medicine, and the appointment of Dr. Victor C. Myers as director of the new department has been announced by President Winfred G. Leutner. The present department of biochemistry, of which Dr. Myers is now director, will be enlarged and a new director will be announced soon, President Leutner said. Dr. Myers will remain at his present post until the new director is named.

Operation of two departments of biochemistry—the clinical to study the biochemistry of disease and the other to study the chemistry of normal living creatures—follows the British and Canadian custom. It is "somewhat of an innovation in the United States", President Leutner said.

Dr. Myers is probably most widely known for his work in perfecting methods of making blood tests to help the physician diagnose disease. His textbook, "Practical Chemical Analysis of Blood" was the pioneer in the field. This was done while he was head of the department of pathological chemistry at the New York Post-Graduate Medical School, Columbia University, 1912-1924. He developed the blood sugar method employed by the late Sir Frederick Banting and Dr. Charles H. Best in their experiments which led to the discovery of insulin.

Orrville—George T. Dunlap, New York City, has offered to donate \$200,000 to the village for the construction and equipment of a hospital in memory of his first wife and father, both natives of Orrville.

# Licenses Granted to 277 Doctors of Medicine by State Medical Board at Meeting in Columbus, July 31

**L**ICENSES to practice medicine and surgery in Ohio were granted 277 graduates of approved medical schools, who had passed the June examinations, at a meeting of the State Medical Board in Columbus, July 31.

Twenty-two recent graduates of osteopathic schools received certificates to practice osteopathic medicine and surgery. In addition, certificates to practice osteopathic medicine and surgery were granted 25 osteopaths, previously licensed, who had met additional requirements and were successful in special examinations entitling them to the new certificates.

The Board also granted certificates in their respective limited branches to 2 mechano-therapists; 5 chiropractors; 3 chiropodists; 1 midwife, the third in 15 years; 4 masseurs, and 8 cosmetic-therapists.

Dr. Charles J. Staley, Columbus, a graduate of Ohio State University College of Medicine, made the highest grade, 88.3 per cent, in the medical examinations. Two graduates of Western Reserve University School of Medicine, Dr. Donald A. Scholz, Medina, and Dr. James L. Hanna, Cleveland, were a close second and third, with grades of 87.2 and 87.1, respectively.

The following doctors of medicine were granted licenses:

**OHIO STATE UNIVERSITY COLLEGE OF MEDICINE**—Thomas James Atchison, Alliance; Wade A. Bacon, Camp LeJeune, North Carolina; Rex Mitchell Bleakney, Columbus; Robert William Bohl, Hillsboro; George T. Bradford, Cleveland; Robert Lape Brown, Greenfield; William Eugene Burkhardt, Columbus; Samuel G. Clark, Columbus; Dwight Howard Davies, Blacklick; Dale Raymond Dickens, Crooksville; Thomas O. Dickey, Jr., Columbus; Walter Peter Drake, Marion; Ray Eugene Ebert, New Holland; Mildred Been Fertman, Youngstown; Samuel Finck, Cleveland; Henry L. Floyd, London; Lewis Francis, Troy; Alan Louis Frankel, Cleveland Heights.

Robert M. Geist, Jr., Columbus; Ivan Samuel Gilbert, Bexley; Sanford Glanz, Cleveland; Robert Elmer Glasgow, Columbus; Frank O. Good-nough, Bridgeport, Conn.; Kenneth L. Graham, Bexley; John Porter Greenlees, Marietta; Roger Waldrick Gridley, Orlando, Fla.; William Val Gross, Jr., Cleveland Heights; John Frederick Harley, Zanesville; Charles Joseph Hatfield, Columbus; Robert August Heilman, Marietta; Ned Barney Hein, Toledo; Jack George Gilbert Hendershot, Canton; Robert Duane Hendrickson, Jamestown; William Garrett Henry, Toledo; Harold Frank Hoprich, Columbus; William Edward Hunt, Columbus; John Winans Hutchison, Columbus.

Marvin Jaffe, Youngstown; Richard Vearl Jaynes, Columbus; Roland Wynn Jones, Newark; Charles Linn Kagay, Columbus; Steve Eugene Keister, Columbus; Joseph D. Kiener, New Lexington; Charles Hawn Klippel, Jr., Columbus; Ernest Peart McLaughlin, Columbus; Bernard Herman Marks, Cleveland; Lawrence C. Meredith, Jr., Columbus; William Robert Morse, Van

Wert; Anna May Newton, Toledo; Carl Richard Reed, Lancaster; Raymond Edward Reinert, Bexley.

Martin Peter Sayers, Columbus; Mark Louis Saylor, Canal Winchester; William R. Shelton, Galion; Lloyd V. Shields, Jr., Columbus; William Norris Slinger, Massillon; William Brown Smith, Newton Falls; Edwin F. Snider, Shelby; Robert R. Sommer, Grove City; Harry E. Sprang, Columbus; Charles Joseph Staley, Columbus; William Frederick Stevenson, Hubbard; William J. Stires, Canton; Robert Elmer Swank, Dayton.

Samuel S. Teitelbaum, Cleveland; Carl Edward Tetirick, Columbus; Richard Charles Troutman, Columbus; Earl Wenman Wade, Broadacre; John Elliott Walters, Columbus; William Thomas Washam, Jackson; Charles Lynn Alfred Wehr, Bellevue; Ernest Harold Winterhoff, Ashville; James Weston Zulliger, Lima.

**UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE**—Joseph Paul Abraham, Cincinnati; David Paul Baumann, Dayton; James John Berens, Cincinnati; Donald N. Berning, Cincinnati; Ralph O. Bosch, Cincinnati; John Brincko, Amsterdam; Jack Brock, New Brocton, Ala.; Harold R. Brodman, New York; Elizabeth Beekley Brodman, New York; John Robert Brown, Cincinnati; Harry Wallace Camp, Jr., Cincinnati; Harold J. Cunlon, Cincinnati; Wallace Hady Cook, Stasca, Ill.; Howard R. Crawford, Cincinnati; Jean Frederick Crum, Lodi.

Arthur S. Dale, Jr., Seymour, Indiana; John R. Ervin, Cincinnati; Frank Filmore Espey, Xenia; Theodore Edward Finigan, Dallas, Texas; Saul Finer, Cincinnati; Harley Harrison Frey, Jr., Toledo; John Charles Fuhs, Cincinnati; William G. Gaenge, Jr., Cincinnati; Thomas Alfred Gardner, Norwood; Joseph Ginsburg, Cincinnati; Jack Molloy Glenn, Cincinnati; Sylvan A. Golder, Cincinnati; William Richey Graf, Cincinnati.

John Biddle Hamsher, St. Paris; Robert Albert Helm, Cincinnati; Harry Oberhelman Hendrick, Cincinnati; Robert John Herman, Toledo; John Joseph Hesselbrock, Cincinnati; Joseph Howard Hill, Albertville, Ala.; Scovell Meyers Hopkins, Ashland, Ky.; Daniel L. Harrigan, Dayton; William Charles Hugenberg, Cincinnati; Paul Dexter Jones, Cincinnati; Elmer G. Katz, Cincinnati; Robert Sanders Leake, Fort Thomas, Ky.; Martin Lowenthal, New York; Bruce Gregg MacMillan, Cincinnati; William Kessler Marple, Cincinnati; S. Gregory Miceli, Cincinnati; Roland Virgil Murphy, Toledo.

Frank Joseph Niesen, Cincinnati; Leo Eugene Palmer, Dayton; Margaret A. Paul, Cincinnati; Sidney Aaron Peerless, Cincinnati; Robert Junior Peirce, Cincinnati; Glenn Louis Pfister, Cincinnati; Fred Herschell Priebe, R. 1, Ladoga, Ind.; Gene Warren Rogers, Cincinnati; Kenneth Dyer Rogers, Cincinnati; Charles David Scheibert, Trenton; James Russell Scheip II, Tipp City; Paul Arthur Schuster, Cincinnati; Ralph Carmen Scott, Bethel; Frank E. Shaw, Cincinnati.

Jack Irwin Smith, Dayton; Robert Charles Smith, Covington, Ky.; William R. Sneed, Jr., Hamilton; Earl Glenn Solomon, Cincinnati; John A. Stewart, Hamilton; Robert Arthur Thompson, Somerset, Pa.; Eldon Bryant Tucker, Jr., Morgantown, W. Va.; James Edward Verbryke, Cincinnati; Glenn Morrison Weaver, Cincinnati; James Hugh Webb, Nelsonville; Richard John Wever, Cincinnati; Daniel Anthony Whalen, Cin-





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James Martin Cary, Hartford, Conn.; Peter C. Castiglia, Passaic, N. J.; John David Chase, Detroit, Mich.; James Henry Christie, Cleveland; Henry Dale Cook, Toledo; John J. Coury, Jr., Cleveland; James William Craig, West Liberty; Frederick Samuel Cross, Toledo; Constance Curtiss, Cleveland Heights; Dean Fletcher Davies, Cleveland; Hamilton Seymour Davis, Shaker Heights; Walter Grayburn Davis, Cleveland; Adam Benjamin Denison, Jr., Shaker Heights; John Harlan Dix, Wooster; William Conrad Downing, Cleveland; Arthur Franz Dundon, Sr., Alliance; Robert W. Dunlap, Jr., Cleveland; Robert Murray Dworkin, University Heights.

Paul William Ebert, Cleveland; Murl Eumund Faulk, Jr., Cleveland; Floyd Josephine Field, New London; Gene Donald Fry, Youngstown; George Harvey Garrison, Columbus; Paul Glendinning, Cleveland Heights; Arthur Chester Gorbach, Jr., Vermilion; John B. Gross, Lakewood; Paul W. Hanahan, Cleveland; Edward Joseph Hanley, Jr., Cleveland Heights; James Lawrence Hanna, Cleveland; Clarence L. Hans, Jr., Cincinnati; Mart L. Helfrich, Jr., Galion; Donald Earle Hughes, Philo; John Edwan Imbody, Marion; Scott Russell Inkley, Cleveland.

Ilse Elsie Jaenchen, Youngstown; John Crow Jarrett, Ellwood City, Pa.; Robert Alvin Keller, Cleveland; Alan L. Klein, New York; Thorp Alexis Klumph, Jr., Canton; William Gebans Kraus, Akron; David Scott Leighninger, Cleveland; Matthew Nathan Levy, Cleveland; John Fergers Lindsay, Jr., Cleveland; Jane Power McCollough, University Heights; Charles Joseph Miller, Jr., New Philadelphia; William Franklin Miller, Cleveland; Alfred Eugene Neale, Toledo; Frederick Alan Oldenburg, Cleveland; Jack Evan Owens, Lakewood; David Parmenter Paull, Essex, Mass.; Harold Mitchell Peck, Cleveland; William Edmond Purvis, III, Franklin, Pa.

Thomas Howard Redding, East Cleveland; Robert Eugene Rinderknecht, Dover; Richard Clem Roeseemann, Cleveland; Donald August Scholz, Medina; Robert Bruce Scribner, Conneaut; Byers Wendell Shaw, Cleveland; Fred Coulter Shipp, Jr., Cleveland; Vincent James Sidoti, Cleveland; Henry Harlow Skinner, Jr., French Camp, Calif.; Paul Jason Slosser, Cleveland; Stuart Werner Smith, Ravenna; Viola Virginia Startzman, Caldwell; Raymond M. Steinberg, Toledo; Homer Earle Stewart, Hoopeston, Ill.; Richard Edgar Straith, Cleveland; Paul Jacob Steuber, Jr., Lima; Charles Hugh Toomey, Lakewood; Warner W. Tuckerman, East Cleveland; Louis J. Turon, Old Forge, Pa.; Judith Hawley Ulrich, Cleveland; Howard F. Van Noate, Doylestown; Robert E. Yeakley, Cleveland; Duncan A. McLaughlin, Cincinnati.

**GRADUATES OF OTHER SCHOOLS**—Cornelius Bickett DeCourcy, Cincinnati, Columbia University; John Alfred Hudec, Cleveland, Georgetown University; Alton J. Ball, Caldwell; Americo Leonard Barreiro, Geneva; Thomas Pat-

rick Berry, Rocky River; Paul Fisher Boyd, Wilmington; Edgar Cross Davis, Jr., Dover; John Oliver Duey, East Cleveland; Jess Edward, Freeport, N. Y.; John E. S. Shuttleworth, East Cleveland; Richard Miller Steinhilber, Philadelphia, Pa.; Ernest Earl Trout, Philadelphia, Pa.; Joseph Ellis Turner, Jr., Chester, Pa.; Harry Molineaux Wildblood, East Liverpool, Hahnemann Medical College; Warren Conrad Breidenbach, Jr., Dayton, Harvard Medical School.

Edward J. Palmer, Cambridge, Mass., Harvard Medical School; Carl Curtis Beckwith, Cleveland, Howard University; Mitchell Wright Spellman, Cleveland, Charles Joseph Cross, Westerville, Frederick Melvin Douglass, Jr., Toledo, Ben Marr Lanman, Gahanna, Frederick Arthur Resch, Youngstown, Jefferson Medical College; Walter Henry Hartung, Jr., Toledo, John Frederick Kuehn, Toledo, Walter Albert Wichowski, Toledo, Loyola University; Harry Blaine Durham, Jr., Casper, Wyo., Charles Nicholas Horvath, Cleveland, Northwestern University; Dorothy Jane Hicks, Cleveland Heights, Henry George Krueger, Lakewood, Temple University.

Donald G. Veber, Shaker Heights, University of Buffalo; Richard Vincent McKay, Jr., General Hospital, Cincinnati, Univ. of Chicago; Charles N. Versteeg, Cleveland, University of Oregon; Alfred Hunter Magness, Coshocton, Robert Bruce Marshall, Jr., Youngstown, University of Pennsylvania; John Reuben Bottomy, Massillon, James F. Fortune, Ashtabula, Francis Wynne Masters, Cleveland, Bernard Hyson Pender, Rochester, N. Y., Wm. K. Rogers, Salem, Franklin H. Schaefer, Jersey City, N. J., Paul Edward Wasson, Canton, University of Rochester; Atha Edwin Draper, Saginaw, Mich., McGill University; Arthur Frankel, Cleveland, University of Bologna, Italy.

## Two New Departments Established at Western Reserve Medical School

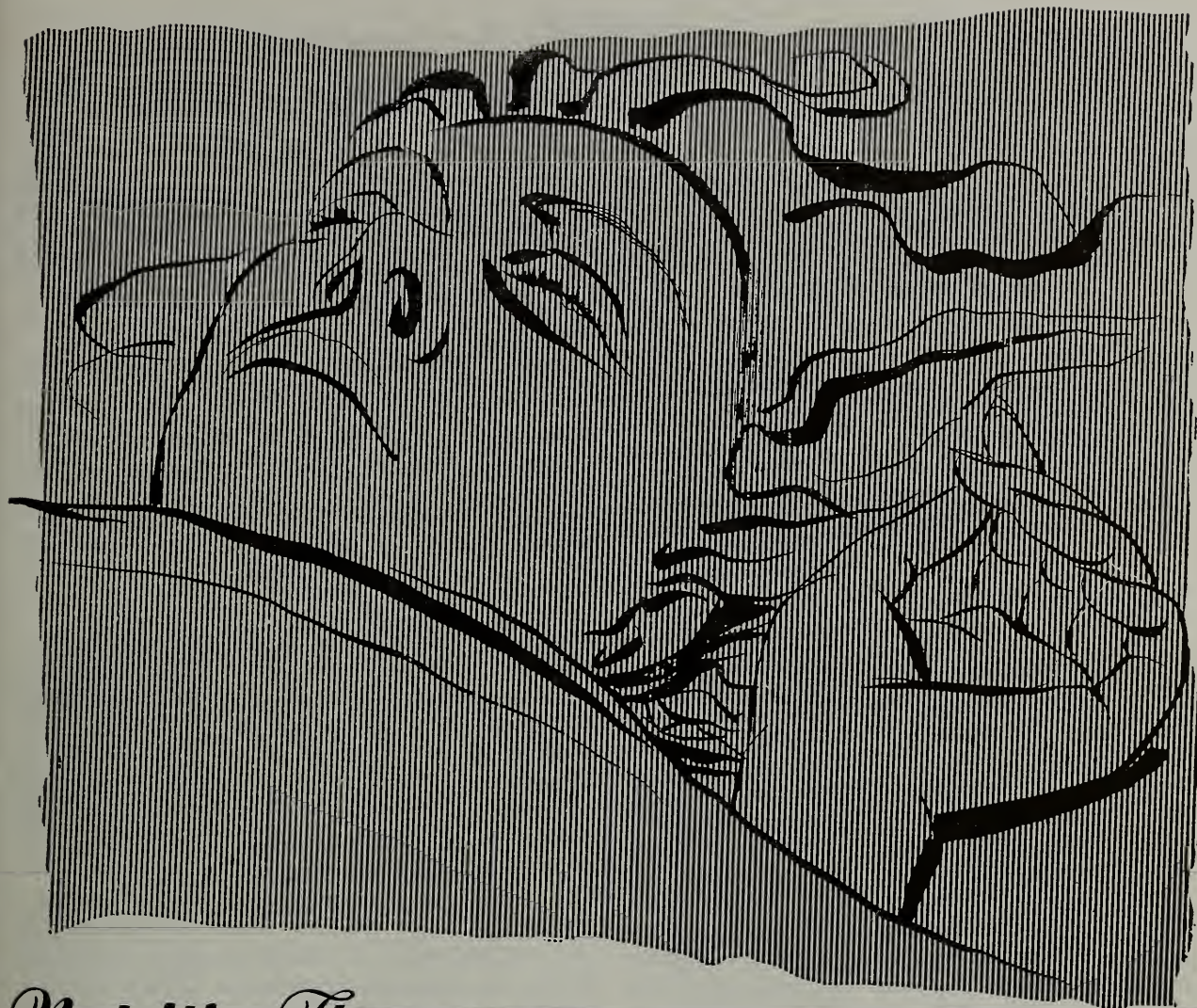
Formation of two new departments in the School of Medicine, Western Reserve University, has been announced by President Winfred G. Leutner.

The Department of Preventive Medicine and Public Health and the Department of Bacteriology have been created through the division of the Department of Hygiene and Bacteriology.

President Leutner also announced the creation of the Elisabeth Severance Prentiss Chair in Preventive Medicine, to be occupied by Dr. James A. Doull as head of the Department of Preventive Medicine and Public Health. The operation of the Department of Preventive Medicine and Public Health will be financed by an annual income from the Elisabeth Severance Prentiss Fund. It is hoped that this sum will be increased by grants from Foundations and other sources.

Details of the organization of the Department of Bacteriology and the appointment of a director of that department will be announced later. Dr. Doull pointed out that separation of the teaching of bacteriology from the Department of Public Health follows the modern trend in medical science. Bacteriology has become a highly specialized field in itself, involving the study of the various organisms that cause disease, as well as the chemistry of the body that sets up immunity against disease, he said.





## Nutritive Therapy

When the nutritive status of any patient is severely impaired, supportive therapy centers about four essential measures<sup>1</sup>.

1. High caloric, high protein diet, within the tolerance of the patient.
2. Prompt administration of thiamine, riboflavin, niacinamide and ascorbic acid in dosage which clinical experience<sup>1,2</sup> has shown to be effective.
3. The natural B complex<sup>1</sup> in adequate dosage.
4. Additional administration of vitamins<sup>2</sup>, calcium, and iron, if and as indicated.

Specific vitamin deficiencies, excepting in the case of vitamins D and K, are usually symptomatic of generalized nutritive failure. Many seeming contradictions in the literature become clear when this is understood. Use of the specific vitamins alone is at best symptomatic treatment and will not restore the patient to full health.

For further information write to Squibb Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

(1). Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. (2). Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

# SQUIBB Nutritive Agents

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# Congress Asked To Enact Laws To Establish Scientific Research Program and Measures To Extend Federal Activities for Maternal and Child Health

A SERIES of proposals of importance to the medical profession has been introduced in the United States Congress during recent weeks.

These include a number of bills providing for a Federal program to promote scientific research and a bill to expand the present Federal program relating to the health and welfare of mothers and children and crippled children—an extension of present maternal and child health activities of the Federal Government.

In order that Ohio physicians may understand the provisions and intent of these measures, and discuss them intelligently with Ohio Congressmen, the following analyses of them, prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association, are presented as follows:

## Extensive Program to Promote Scientific Research Asked

Identical bills are pending in the Senate and House of Representatives to implement the recommendations contained in the report recently submitted to President Truman by Dr. Vannevar Bush, director of the Office of Scientific Research and Development, and other collaborating scientists, outlining a suggested Federal program to promote scientific research. The Senate bill, S. 1285, introduced on July 19 by Senator Magnuson of Washington, was referred to the Senate Committee on Commerce, of which Senator Bailey of North Carolina is chairman. The House bills, H. R. 3852, introduced on July 19 by Representative Mills of Arkansas, and H. R. 3860, introduced on July 20 by Representative Randolph of West Virginia, have been referred to the House Committee on Interstate and Foreign Commerce, of which Representative Lea of California is chairman.

On July 23 Senator Kilgore of West Virginia, for himself and Senator Johnson of Colorado, and Senator Pepper of Florida, introduced S. 1297, which embodies principles which the Subcommittee on War Mobilization of the Senate Military Affairs Committee, on the basis of extensive studies made over the past two years, has set up as desirable in any legislation designed to meet the postwar scientific needs of the nation. The bill is pending in the Senate Committee on Military Affairs, of which Senator Thomas of Utah is chairman.

Representative May of Kentucky has introduced another bill relating to scientific research, H. R. 3440. This bill would authorize an appropriation of not to exceed \$8,000,000 annually to enable the National Academy of Sciences, through a research board for national security consisting of representatives of the Army, Navy and civilians of outstanding accomplishments,

to provide for scientific research and advancement determined by the board to be desirable in the interest of national security. It has passed the House of Representatives and is pending in the Senate Committee on Naval Affairs.

## ADDITIONAL MEASURES

Another pending bill, S. 825, was introduced by Senator Byrd of Virginia on April 4 and was referred to the Senate Committee on Naval Affairs, of which Senator Walsh of Massachusetts is chairman. It would create a Research Board for National Security to include representatives of the Army and Navy, the chairman of the National Advisory Committee for Aeronautics and civilian scientists, engineers or industrialists. It will be the duty of the board to formulate programs of scientific research and development relative to problems of national security. The term "science" as used in the bill includes the employment of scientific methods of analysis, experiment and test in any "branch of science or technology, including engineering, medicine, dentistry, psychology and biology". This bill was favorably reported to the Senate July 28, with amendments.

Another bill has been introduced in the Senate by Senator Fulbright, Arkansas, S. 1248. It proposes to establish a Bureau of Scientific Research in the Department of Commerce "to aid, encourage, and protect the research and enterprise of inventors, scientists, technicians, scientific and educational institutions, and research laboratories engaged in scientific and technical work, and to make their resultant discoveries and data more readily available, without discrimination, to all sections of industry, agriculture, and the public in order to promote full employment and higher standards of living". This bill is pending in the Senate Committee



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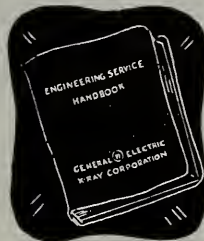
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on Commerce, of which Senator Bailey, North Carolina, is chairman.

With the exception of the three bills designed to implement the recommendations contained in the Bush report, these proposals differ in many details; that fact was given recognition by Senator Kilgore at the time he introduced his bill. After referring to the other pending legislation, he expressed the hope that arrangements could be made for joint hearings "so that the issues presented by these different bills can be clarified and agreement reached at an early date on the scope of research needed in the interest of national security and also on the details of organization and administration so essential to the success of any national program of scientific research".

There follows a factual analysis of the Magnuson-Mills-Randolph bill and the Kilgore bill.

#### THE MAGNUSON-MILLS-RANDOLPH BILL

This legislation would create a National Research Foundation as an independent agency in the executive branch of the government to secure the full development and application of the nation's scientific and technical resources for national defense, prosperity, health and welfare.

**Administrative Board**—The powers and duties of the foundation will be exercised by a board of nine members appointed by the President without regard to political affiliations and solely on the basis of their demonstrated interest in and capacity to promote the purposes of the foundation. The board will be authorized to employ a director at a salary of \$15,000 a year, who will be the principal executive officer of the foundation. Two deputy directors may be appointed by the director, each of whom will receive compensation at the rate of \$12,000 a year. The members of the board will serve without compensation, but will be allowed actual and necessary traveling and subsistence expenses when engaged, away from home, in the duties of their office.

**Divisions Within Foundation**—Within the foundation there will be a minimum of five divisions as follows: (1) a Division of Medical Research to carry out programs relating to research in biologic science, including medicine and the related sciences; (2) a Division of Physical Sciences to carry out programs relating to research in the mathematical and physical sciences; (3) a Division of National Defense to carry out programs relating to scientific research on military matters; (4) a Division of Scientific Personnel and Education to carry out the program relating to the grant of scholarships and fellowships in the mathematical, physical and biologic sciences, and (5) a Division of Publications and Scientific Collaboration to carry out programs relating to the public dissemination of scientific

information among scientists. Additional divisions may be created by the board.

**Committees Within Divisions**—In each division will be a committee of not less than five members appointed by the board after receiving recommendations from the National Academy of Sciences. The committee within the Division of National Defense, in addition, will include a member designated by the Secretary of War and a member designated by the Secretary of the Navy.

The appointed members will receive compensation at the rate of \$50 a day while engaged in the business of the foundation plus expenses when engaged, away from home, in the duties of their office. Each committee will make recommendations to and advise and consult with the board and the director with respect to matters of its division. Additional powers and duties may be devolved on the committees by the board.

**Powers and Duties of the Foundation**—In carrying out the purposes of the bill, the foundation will be authorized and directed:

- (1) to develop and promote a national policy for scientific research and scientific education;
- (2) to initiate and support basic scientific research and scientific development in the mathematical, physical and biologic sciences through contracts, grants or other forms of assistance;
- (3) to initiate and support scientific research and scientific development on matters relating to the national defense through contracts, grants or other forms of assistance;
- (4) to discover and develop scientific talent, particularly in American youth;
- (5) to grant scholarships and fellowships in the mathematical, physical and biologic sciences;
- (6) to foster the interchange of scientific information among scientists in this country and abroad; and
- (7) to correlate the foundation's scientific research and scientific development programs with those undertaken by public and private research groups.

**Authority of Foundation**—The foundation will be specifically authorized (1) to prescribe such rules and regulations as it deems necessary; (2) to enter into contracts, or amendments or modifications of contracts without legal consideration, without performance or other bonds in the case of all contracts which relate to scientific research or scientific development; (3) to make advance, progress and other payments which relate to scientific research or scientific development; (4) to acquire by purchase or otherwise, hold and dispose of by sale, lease, loan or otherwise real and personal property of all kinds necessary for or resulting from scientific research or scientific development without regard to the provisions of law relating to the acquisition, holding or disposition of property by the United



States; (5) to receive and use funds donated by others, provided such funds are donated, without other restriction, in furtherance of one or more of the general purposes of the foundation; (6) to publish or arrange for the publication of scientific and technical information so as to further the full dissemination of information of scientific value consistent with the national interest; (7) to accept and utilize the services of voluntary and uncompensated personnel and to pay the actual and necessary traveling and subsistence expenses, including in lieu of subsistence per diem at a rate not in excess of \$10, of such personnel incurred in the course of such services; (8) to prescribe the extent to which vouchers for funds expended under contracts for scientific research and development shall be subject to itemization or substantiation prior to payment, without regard for the limitations of other laws relating to the expenditure of public funds and accounting therefor; (9) to establish a National Science Reserve in which will be enrolled all those who receive scholarships and fellowships in science and medicine from the foundation. Members of the National Science Reserve will be available for call into the service of the government for scientific and technical work in time of war or other national emergency as declared by the Congress or proclaimed by the President.

**Appropriations**—The bill will authorize to be appropriated annually to the foundation such sums as may be necessary to carry out its provisions. Funds appropriated for the foundation will, if obligated during the fiscal year for which appropriated, remain expendable for a period of four years. After such a four-year period, the unexpended balances will revert to the treasury.

**General Provisions**—The bill specifically provides that the foundation shall not itself operate any scientific or technical facilities of its own.

There will be transferred to the foundation all powers, functions and duties of the Office of Scientific Research and Development and its constituent committees. All personnel, property, records, funds, contracts, assets and liabilities of the Office of Scientific Research and Development, and of its constituent committees, will also be transferred to the foundation. This transfer will take effect at such time as the President directs.

Members of the board and members of the committees within the divisions may engage in private and gainful employment, but no compensation for such employment may be received in any form by any such member (1) from any profit-making organization which receives funds under contract, or otherwise, within the cognizance of the division or divisions of the foundation with which such member is concerned or

(2) in respect of any particular matter which directly involves the foundation or in which the foundation is directly interested.

The director will be authorized to appoint and fix the compensation of necessary personnel, subject to the provisions of the civil service laws and regulations and the Classification Act of 1923. Technical and professional personnel may be employed without regard to the provisions of the Classification Act. The director, the deputy directors and the members of the committees within the divisions will also be appointed without reference to the civil service laws or the Classification Act.

The foundation will be required to submit an annual report in writing to the President and the Congress and the bill, if enacted, will be cited as the "National Research Foundation Act of 1945".

#### THE KILGORE BILL

The title of the Kilgore bill, S. 1297, indicates its purpose, namely, to promote the progress of science and the useful arts, to secure the national defense and to advance the national health and welfare.

**National Science Foundation**—An independent agency of the Federal Government to be known as the National Science Foundation will be created. It will be administered by a director appointed by the President, by and with the advice and consent of the Senate. His salary will be \$15,000 a year.

The director will be required to consult and advise with a National Science Board on all matters of major policy or program. The board will consist of the director as chairman, the heads of the Departments of War, Navy, Justice, Interior, Agriculture, Commerce and Labor, and the Federal Security Agency or their designees, plus eight public members appointed by the President by and with the advice and consent of the Senate.

**Promotion of Research and Development**—The foundation will be required to give particular attention to promoting research and development activities relating to (1) national defense, (2) health and medicine, (3) the basic sciences, (4) the conservation, development and use of the natural resources of the nation, (5) the development of methods and processes beneficial to small business enterprises and (6) the adaptation to peacetime use of wartime research and facilities.

Not less than 20 per cent of the funds to be made available to the foundation for research and development activities will be expended for research and development in each of the following fields: (1) national defense and security and (2) health and medicine.

The bill requires the foundation to consider the desirability of utilizing facilities available in departments and agencies of the Federal Government, state and local governments, educational



institutions, research institutions, private industrial organizations, and individual scientists particularly qualified to carry out such projects. Not less than 50 per cent of the total funds appropriated by the Congress for research and development activities under the bill must be expended for engaging the facilities of qualified nonprofit educational institutions and research institutions.

**Committees Within Foundation**—A minimum of two committees within the foundation are to be established: (1) a Research Committee for National Defense consisting of a chairman to be appointed by the President by and with the advice and consent of the Senate, whose salary will be \$12,000 a year, and nine members at large, three to be designated by the Secretary of War, three by the Secretary of the Navy and three by the director with the advice and approval of the board; and (2) a Research Committee for Health and the Medical Services, consisting of a chairman appointed by the President by and with the advice and consent of the Senate, whose salary will be \$12,000 a year, and nine members at large, of whom three shall be designated by the administrator of the Federal Security Agency and six by the director with the advice and approval of the board.

The members at large to be appointed by the Secretaries of War and the Navy and the administrator of the Federal Security Agency may be civilian or military employees of the government or public members. The director will be required to advise with these two committees with respect to the formulation of over-all research and development programs in the fields of national defense and health and medicine and must secure the approval of the committees with respect to the determination of specific projects and the selection of specific facilities.

Additional advisory committees may be set up by the director, and members of such committees will be appointed by the director by and with the advice and consent of the board and, in appointing such members, the director may request appropriate national scientific organizations to submit panels of candidates from which he may make his selection.

**Scholarships and Fellowships**—The foundation will be authorized to grant scholarships and fellowships to persons showing special aptitude, for one year's study at a nonprofit institution of higher education or other nonprofit institution. Scholarships and fellowships are to be renewable for a period up to five years at the option of the foundation.

**Survey of Federal Scientific Activity; Dissemination of Research Findings**—The foundation will be required to make and maintain a comprehensive survey of Federally financed research and development activities. Any agency engaged in

such activities will be required, on request by the director, to furnish whatever data and reports may be needed. The foundation must evaluate such survey data and make recommendations to the President and the agencies concerning improvements.

Each contracting organization or institution or individual, as a condition to receiving financial support from the foundation, will be required to make available full data on all inventions, discoveries and other significant findings. The foundation will be directed to collect, edit, publish and disseminate pertinent data on all inventions, discoveries and other findings resulting from Federally financed research and development activities. It must take such steps as necessary to disseminate such data to the public, including the preparation of abstracts, translations, bibliographies and microfilm reproductions of research and development reports and publications.

The foundation will be required to do what it can to eliminate restraints on the free expression of scientific truths and to insure ample freedom in the exercise of creative talents and in the development of promising new ideas in connection with all research and development projects promoted, financed or otherwise supported by the Federal Government.

All materials or equipment purchased or furnished by Federal funds in connection with research and development projects, and any invention, discovery or finding resulting from such Federally financed projects shall be the property of the Federal Government.

**Restriction on Dissemination of Information**—The Defense Committee must declare secret or restricted any scientific or technical information, data, patents, inventions or discoveries in or coming into the possession or control of the foundation, the secrecy or restriction of which the President or his designee or designees certify as being essential in the interest of national defense.

**Patents**—The director will be required to patent all significant inventions or discoveries resulting from research and development projects. Any citizen, corporation or other organization desiring to use any invention, discovery or patent which is or may hereafter become the property of the United States will, on proper application, be granted without further limitation a nonexclusive license for which there will be no charge. The foundation will be required, however, to refuse to grant a license to any applicant on a finding in writing by the Department of Justice to the director that the granting of such license will tend to promote or result in a monopoly or a practice which is in restraint of trade.

**Appropriations**—Such sums as may be necessary to carry out the provisions of the bill may



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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

*Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241  
*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.

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be annually appropriated by the Congress to the foundation. In addition, the foundation may solicit and receive financial grants, personal services and any other aid furthering scientific and technical progress, may enter into contracts and make expenditures for personnel, equipment and services as it may deem necessary. The foundation may not itself through its own employees operate any laboratories, pilot plants or other such scientific or technical facilities which it may acquire.

**Employment of Personnel**—The director will be authorized to appoint and fix the compensation of necessary personnel. Appointments and compensation shall be made in accordance with the provisions of the civil service laws and the Classification Act, except that technical and professional personnel may be employed without regard to such laws.

Public members of the board and of any advisory committee will serve without remuneration except for per diem allowances, transportation and other necessary expenses incurred. No employee of the foundation or member of any advisory committee may participate in any decision or recommendation affecting his personal financial interest or the activities of any organization in which he has a financial interest or by which he is employed.

**"Research and Development" Defined**—These terms are declared to mean not only theoretical analysis, exploration and experimentation but also the extension of investigative findings and theories of a scientific or technical nature into practical application, including the preparation of plans, specifications and standards for various goods and services, the undertaking of related economic and industrial studies, the experimental production and testing of models, and the building and operation of pilot plants.

**Miscellaneous**—The director must render an annual report in writing to the President and to Congress, summarizing the activities of the foundation and containing such recommendations as he may deem appropriate. The foundation will be granted the free use of the mail. As used in the bill, the term "Federally financed" means financed in whole or in part by the Federal Government. The bill, if enacted, will be cited as the "National Science Foundation Act of 1945".

## Enlarged U. S. Maternal and Child Health Program Proposed

Senator Pepper, Florida, for himself and nine other members of the Senate Committee on Education and Labor, has introduced a bill, S. 1318, to provide for the general welfare by enabling the several states to make more adequate provision for the health and welfare of mothers and children and for services to crippled children and for other purposes. Joining Senator Pepper

in sponsoring this legislation were Senator Walsh, Massachusetts; Senator Thomas, Utah; Senator Hill, Alabama; Senator Chavez, New Mexico; Senator Tunnell, Delaware; Senator Guffey, Pennsylvania; Senator LaFollette, Wisconsin; Senator Aiken, Vermont, and Senator Morse, Oregon. The bill was referred to the Senate Committee on Education and Labor, of which Senator Murray, Montana, is chairman.

An appropriation of \$100,000,000 will be authorized for the fiscal year ending June 30, 1946: \$50,000,000 earmarked for maternal and child health services, \$25,000,000 for services for crippled children, \$20,000,000 for child welfare services and \$5,000,000 for expenses necessary to enable the Children's Bureau to administer the provisions of the bill and to develop and promote effective measures for carrying out its purposes, including "studies, demonstrations, investigations and research, the training of personnel for Federal, state and local service, and the payment of salaries and expenses of personnel detailed at the request of state agencies to cooperate with and assist such agencies" in carrying out the objectives of the legislation. Thereafter such sums will be made available as the Congress shall decide.

The bill, which Senator Pepper has described as "a modest beginning", has five titles:

### TITLE I. MATERNAL AND CHILD HEALTH SERVICES

The stated objectives of this title are to provide and maintain services and facilities to promote the physical and mental health of mothers during the maternity period and of children, including medical, nursing, dental, hospital and related services and facilities required for maternity care, preventive health work and diagnostic services for children, school health services, care of sick children, and correction of defects and conditions likely to interfere with the normal growth and development and the educational progress of children. The development of more effective measures for carrying out the purposes of the title is contemplated, including demonstrations and the training of personnel for state and local maternal and child health services.

Of the total appropriation to be made available under this title, \$5,000,000 will be allotted by the Secretary of Labor to the several states, and allotments must be matched dollar for dollar by state or state and local funds. In determining what amount each state shall be allotted, the Secretary of Labor will take into consideration the number of children under 21 years of age in such state in relation to the total number of children under 21 years of age in the United States.

The remainder will be allotted to the states



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by the Secretary of Labor after taking into consideration for each state such factors as the number of mothers and children under 21 years of age in the state for whom the services and care are to be made available, and the cost of furnishing such services and care to them, the special problems of maternal and child health and the financial need of the state for assistance in carrying out the state plan.

**Approval of State Plans**—Allotments will be paid to those states whose plans for developing programs and for providing care and services have been approved by the chief of the Children's Bureau. In order for a plan to be approved by the chief of the Children's Bureau, it must:

1. Provide for financial participation by the state.

2. Provide for a statewide program or for extension of the program each year so that it will be in effect in all political subdivisions by July 1, 1955.

3. Provide that services and facilities shall be available to all mothers and children in the state or locality who elect to participate in the benefits of the program. There must be no discrimination because of race, creed, color or national origin, and no residence requirements.

4. Provide for the administration of the plan by the state health agency, or for the supervision of the administration of the plan by the state health agency, and for appropriate coordination of the plan with the general public health and medical care program of the state health agency which will be authorized to develop agreements or cooperative arrangements with other state or local public agencies whose functions include the provision of services similar or related to those furnished under the state plan.

5. Be made part of the state plan for maternal and child health services submitted in accordance with the provisions of Title V, Part 1, of the Social Security Act.

6. Provide effective methods of administration, including the establishment and maintenance of personnel standards on a merit basis, standards for professional personnel rendering medical, dental, nursing and related types of care or service, and standards for hospital and other institutional care and services. Standards are to be established by the state health agency after "consultation" with the professional advisory committees appointed by the state health agency. Mothers and children, or persons acting in their behalf, will be permitted to select, from among those meeting standards prescribed by the state health agency, the physician, hospital, clinic or health service agency of their choice. Where no such selection is made, the state plan must set forth the method by which the care will be made available. The bill provides that the physician, hospital, clinic or health service agency selected may refuse to accept the case.

A state plan must provide for adequate remuneration for the persons and institutions providing medical care and related services, must provide opportunities for postgraduate training of professional and technical personnel, and for such use of health centers, hospitals, clinics, and health service agencies, public and voluntary, as will achieve the satisfactory distribution and coordination of preventive, diagnostic, consultative and curative services provided by general practitioners, specialists, public health personnel, laboratories and others.

A state plan must provide payments to individual physicians for care furnished under this title on a per capita, salary, per case or "per session" basis or, in the case of consultations or emergency visits, on a fee-for-service basis. A state plan must furthermore provide for the purchase of care from public or voluntary hospitals and other health service agencies included under the state plan on a basis related to cost for providing the care.

7. Provide for adequate dissemination of information with regard to the maternal and child health services to be made available under this title.

8. Provide for reports to the chief of the Children's Bureau.

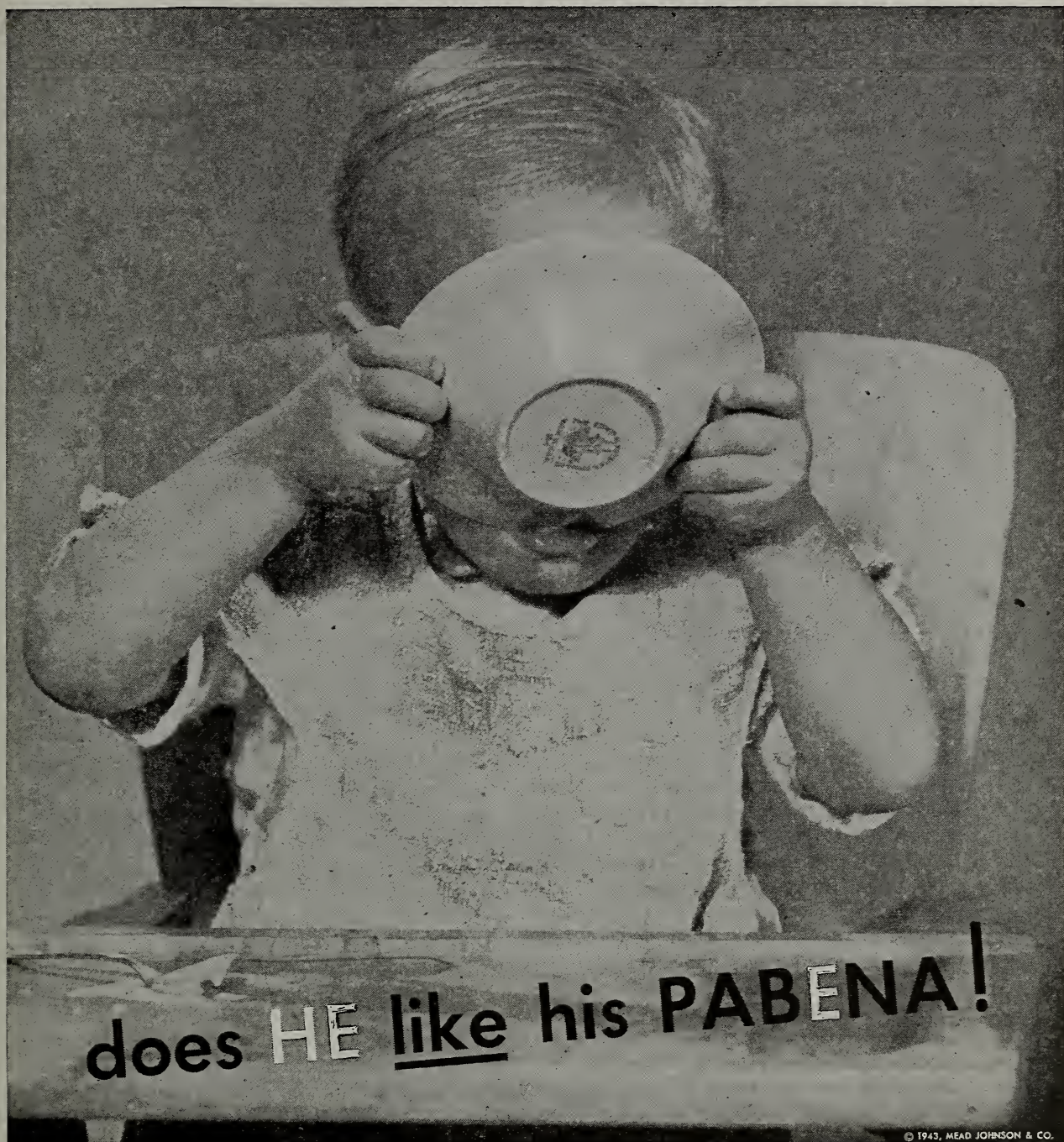
9. Provide for cooperation with medical, health, hospital, nursing, education and welfare groups and organizations in the state.

10. Provide (a) for a general advisory council appointed by the state health agency and composed of members of the professions or agencies, public and voluntary, that furnish care or services under the state plan, and other persons representing the public who are informed on the need for and problems related to the provision or receipt of maternal or child health services and medical care of mothers and children, and (b) for technical advisory committees appointed by the state health agency composed of medical and other professional groups concerned with the administration or operation of a state plan. If the state health agency administers a program for services to crippled children, the same general advisory council shall serve both the maternal and child health and the crippled children programs.

11. Provide for a fair hearing before the state health agency for any mother or other person acting in behalf of a child whose claim for services is denied or for any physician or other person, organization or institution participating or desiring to participate in furnishing services or facilities under the plan.

**Federal Advisory Committees**—The chief of the Children's Bureau will formulate general policies for the administration of this title after "consultation" with a conference of state health officers and an advisory committee composed





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of professional and public members and, as necessary, technical advisory committees which "he" shall appoint.

#### TITLE II. SERVICES FOR CRIPPLED CHILDREN

The stated objectives of this title are to enable each state to provide and maintain services and facilities for the care and treatment of children who are crippled, otherwise physically handicapped or suffering from conditions which lead to crippling or physical handicaps, including services for locating such children, for providing medical, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization and after-care for such children. Demonstrations and the training of personnel for state and local crippled children's services are contemplated.

Out of the total appropriation authorized under this title, the Secretary of Labor will allot to each state such part of \$2,500,000 as he finds that the number of children under 21 years of age in such state bore to the total number of children under 21 years of age in the United States in the latest calendar year for which the Bureau of the Census has available statistics. Such allotments must be matched dollar for dollar by state or state and local funds made available for services for crippled children.

The remainder of the appropriation will be allotted to the states by the Secretary of Labor after taking into consideration for each state such factors as (1) the number of crippled children under 21 years of age in the state for whom services and care are to be made available and the cost of furnishing such services and care to them, (2) the special problems of crippled children and (3) the financial need of the state for assistance in carrying out the state plan.

**Approval of State Plans**—Allotments will be made to the states which have submitted to and had approved by the Children's Bureau state plans for developing programs for crippled children. As in the case of state plans developed under Title I, the bill indicates the contents a state plan must have to be approved. Such a state plan for services for crippled children must meet essentially the same requirements specified for plans developed under Title I except that, if a state agency other than the state health agency is designated by state law to administer the program for crippled children, that agency may continue as the state administrative agency until July, 1950, after which the state health agency must have jurisdiction. Services to be provided under this title must be available to all crippled children without regard to financial status, race, creed, color or national origin, and there may be no residence requirement. Individual physicians will be paid as indicated in Title I, except that Title II makes no provision for payment on a per capita basis.

**Federal Advisory Committees**—The chief of the Children's Bureau will formulate all general policies for the administration of this title after "consultation" with (1) a conference of executive officers of state agencies administering the program for crippled children under this title and (2) an advisory committee composed of professional and public members and, as necessary, technical advisory committees, which "he" shall appoint.

#### TITLE III. CHILD WELFARE SERVICES

The declared purpose of Title III is to assist each state public welfare agency to develop effective statewide child welfare programs and measures, including the training of personnel, for extending and strengthening public child welfare services, and for providing suitable care and protection for children without parental care and supervision, and children who are dependent, neglected or delinquent, or in danger of becoming neglected or delinquent.

For each of the fiscal years ending June 30, 1946, and June 30, 1947, the Secretary shall allot to each state such part of \$10,000,000 and for the fiscal year ending June 30, 1948, and for each fiscal year thereafter such part of three-fourths of the total amount appropriated for child welfare services as he finds that the number of children under 21 years of age in such state bore to the total number of children under 21 years of age in the United States in the latest year for which the Bureau of the Census has available statistics. Such allotments must be matched dollar for dollar by state or state and local funds made available for child welfare services.

For the fiscal year ending June 30, 1946, and for each fiscal year thereafter the remainder of the sum appropriated for child welfare services will be allotted to the several states by the Secretary of Labor, taking into consideration for each state such factors as (1) the number of children under 21 years of age in the state for whom child welfare services are to be made available and the cost of providing such services and care to them, (2) the special problems of child welfare and (3) the financial need of the state in carrying out the state plan.

**Approval of State Plans**—Allotments will be made to states which have submitted to and had approved by the Children's Bureau state plans for child welfare services. The chief of the Children's Bureau will be required to approve any state plan which meets the following conditions:

(1) Financial participation by the state.

(2) A statewide program, including at least guidance and social service to or in behalf of children who are dependent, neglected or delinquent, or in danger of becoming neglected or delinquent, or for the extension of the program





To the pregnant woman many days seem twice as long as they really are. In spite of precautions, vitamin deficiency induced by fetal needs, unbalanced diet, increased metabolism, and faulty absorption may be added to her other burdens. During this period of many worries, Upjohn vitamins, small and easy to take, make available high potency dietary supplementation at low cost.

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each year so that such guidance and service will be available to all children in need thereof, in all political subdivisions of the state not later than July 1, 1955.

(3) Services and care furnished under the plan must be made available to all children without regard to financial status, race, creed, color or national origin, and without residence requirements.

(4) Administration or supervision of the plan by the state public welfare agency and coordination of the plan with the general public welfare program of the state public welfare agency which will be authorized to develop agreements or cooperative arrangements with other state agencies whose functions include the provision of services related to the services furnished under the state plan.

(5) The state plan must be made a part of the plan for child welfare services submitted in accordance with the provisions of Title V, Part 3, of the Social Security Act.

(6) The plan must provide such methods of administration as are found by the chief of the Children's Bureau to be necessary for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis.

(7) The state public welfare agency must make such reports in such form and containing such information as the chief of the Children's Bureau may from time to time require.

(8) Appropriate cooperation must be provided for with state and local agencies, public and private, concerned with child health, education, child welfare and related subjects.

(9) The plan must provide for a program of training for personnel rendering child welfare services.

**Definitions**—As used in this title, the term "child welfare services" means (1) guidance and social service to or on behalf of children who are dependent, neglected or delinquent, or in danger of becoming neglected or delinquent; (2) placement supervision and maintenance of children in foster family homes; (3) temporary care of children who are dependent, neglected or delinquent, or in danger of becoming neglected or delinquent, especially in areas where children would otherwise be detained in jail or would be deprived of necessary protection and shelter or study of their special needs; (4) specialized services needed to strengthen and improve the programs of public institutions caring for children; (5) care in foster homes or day care centers for children whose mothers are employed or whose home conditions require care outside their own homes during any part of the twenty-four hour day, including services necessary to assure proper use of day care facilities and to safeguard children receiving care; (6) payment

of the cost of returning nonresident children to their own communities; if such return is desirable and the cost thereof can not otherwise be met, and (7) cooperation with state and community agencies in improving conditions affecting the welfare of children.

#### TITLE IV. ADMINISTRATION

If the Secretary of Labor finds that in the administration of any plan approved under the bill there is a failure to comply substantially with any requirement specified as necessary for inclusion in a state plan, he may withhold further allotments.

The Children's Bureau will be directed to make and aid the financing of such studies, demonstrations, investigations and research as will promote the efficient administration and operation of the legislation.

#### TITLE V. GENERAL PROVISIONS

The chief of the Children's Bureau, subject to the approval of the Secretary of Labor, will make and publish such rules and regulations as are necessary to the efficient operation of the legislation and will be required to submit each year to the Congress a full report of such administration.

As used in the bill, the term "state" means any state of the United States, the District of Columbia or any territory or possession of the United States.

#### MISCELLANEOUS

Another bill introduced by Senator Langer, North Dakota, S. 1332, would provide maternity leave for government employees.

H. R. 3761, introduced by Representative Welch, California, proposes to amend in several respects the Longshoremen's and Harbor Workers' Compensation Act. One of the amendments would authorize an injured employee to select to treat him any physician authorized by the commission to render medical care to beneficiaries of the act. The commission would be authorized to establish such panels of qualified physicians, surgeons, specialists, consultants, "laboratory X-ray or other technicians", compensation medical bureaus and laboratories as may be necessary and would be authorized to establish schedules of fees to be charged by those rendering services to beneficiaries.

#### CORRECTION

On page 748 of the August issue of *The Journal* there appeared a typographical error in the editorial commenting on the shortage of medical students. It was stated that "400,000 students will receive the M.D. degree in the period 1942 to 1948". Obviously the figure should have been "40,000".



"but, Doctor, I can't sleep!"

This is a statement that no physician fails to overlook, because regular, adequate sleep is an important factor in the treatment of many clinical conditions.

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### PEPPER BILL PROPOSES SUPER E. M. I. C. PROGRAM

When the Emergency Maternity and Infant Care Program for wives and children of service men was inaugurated two years ago, The Council of the Ohio State Medical Association objected to the provisions of the plan which placed the U. S. Children's Bureau in the role of dictator and suggested certain alternatives which would have accomplished the same ends but without Federal dictation. Those familiar with the events of two years ago know that the State Association was condemned and lambasted for its stand. Its motives were misrepresented in many newspapers and by medical socializers, who waved the flag and stated that this was only a temporary program for the duration of the war, designed to pay a debt which the nation owed to the men in the service.

At that time the medical profession of Ohio stated that it wanted all mothers and children to have the very best obstetrical and pediatric care available. It still holds to that opinion. Nevertheless, it felt then, as now, that as good service for those needing aid can not be provided under a Federally dictated program as under a plan where policy-making and administrative responsibilities are handled by local and state health agencies which enjoy the confidence of members of the medical profession.

Predictions made two years ago that the E.M.I.C. program was merely the opening wedge to a permanent, expansive Federal plan to provide obstetrical and pediatric care for all mothers and children of America was scoffed at by the New Dealers. It would seem, however, that those who made such predictions were not off the beam.

Read the article published elsewhere in this issue regarding the proposal which has been presented to Congress by Senator Pepper and others, calling for a super maternal and child welfare program to be run by the Federal Government!

Few will quarrel with the objectives sought by the Pepper bill. But, it is extremely doubtful that the medical profession can support this piece of legislation as it appears to violate many of the fundamental principles and policies which the profession believes to be essential for maintaining high medical and health standards.

For example, the measure referred to would seem to mean that:

The Federal Government must supply obstetrical and pediatric care irrespective of the individual's ability to pay—socialized medicine under governmental, political control.

The program will be under the direction of the Children's Bureau whose activities in running the E.M.I.C. program have been resented and soundly criticized by many physicians.

The medical advisory committee will have no real power and will be set up so as to give the individual practicing physician little opportunity to express his views.

The initiative in formulating the program will be taken from the individual states and placed in Washington.

The Children's Bureau is given authority to govern by rule, regulation and ukase as it has done in administering the E.M.I.C. plan.

If the Pepper bill is subject to these criticisms—and we think it is—then it is in a class with the Wagner-Murray Dingell Bill and will have to be opposed vigorously by the medical profession, no matter how worthy its objectives, as the objectives will not be attainable under such a system.

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### SHOWDOWN ON WAGNER BILL MAY COME THIS FALL

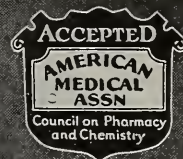
Certain labor leaders and New Dealers are exerting terrific pressure on members of the Congress for early hearings on the 1945 version of the Wagner-Murray-Dingell Bill (S. 1050 and H. R. 3293) which proposes an expansion of the Social Security System and would inaugurate a gigantic compulsory sickness insurance program.

Indications are that hearings will be held this Fall by the House Ways and Means Committee, of which Congressman Thomas A. Jenkins, Iron-ton, Ohio, is a member.

Ohio physicians must get ready for action. Those who have not done so should read every line of the detailed explanation of the Wagner proposal, published in the July issue of *The Ohio State Medical Journal*. Even a casual reading of the sections dealing with the compulsory medical care provisions should convince most physicians that this measure proposes a system of Federalized medicine which would revolutionize the practice of medicine in this country, regiment the profession and jeopardize present medical and health standards.

Ohio physicians should take an aggressive stand against the 1945 version of the Wagner





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Bill and voice their criticisms immediately, not only to their respective Congressman but to their patients, friends and acquaintances.

The public is going to decide this issue but the medical profession's views will play an important part in helping the people decide that this is undesirable legislation. It is time for doctors to speak up; become militant.

The recently announced 14-point platform of the American Medical Association (published in the August issue of *The Ohio State Medical Journal*) offers a constructive general approach toward solution of existing medical and health problems.

Organization of Ohio Medical Indemnity, Inc., by the Ohio State Medical Association and expansion of the Blue Cross Hospital Service programs in Ohio are concrete activities which can be cited as practical and desirable alternatives to a compulsory national sickness insurance plan as proposed by Messrs. Wagner, Murray and Dingell.

Moreover, Ohio's new mental hygiene program and the progressive activities now being carried on by the State Department of Health and many local health and medical organizations, to expand health services, indicate that interference, regulation and dictation by the Federal Government are unnecessary.

The showdown may not be far off. Every physician has a big stake in the outcome. Are you prepared and willing to do your part?

#### NEW V. A. MEDICAL ADVISER FORMER OHIO PHYSICIAN

Appointment by General Omar N. Bradley, new head of the Veterans Administration, of Maj. Gen. Paul R. Hawley as his medical adviser, indicates that General Bradley will make a sincere effort to improve the standards of medical services supplied through the Veterans Administration facilities.

General Hawley made an outstanding record as chief surgeon of the European Theater of Operations during the war with Germany. He is a native of Ohio—College Corners, Butler County, being his birthplace—and a graduate of the College of Medicine, University of Cincinnati, in 1914. Those who knew him then and who have followed his career in the Army Medical Department are confident that he has the experience, training and courage to renovate and modernize the medical program of the Veterans Administration.

The job will not be an easy one. General Hawley will need the cooperation and assistance of the medical profession. We hope he will look to the representatives of practicing physicians for advice, guidance and assistance. We think he will. Also, we hope he will work out a plan whereby the physician in private

practice will be given greater responsibilities and opportunities to serve the disabled veteran. In our opinion there has been too much centralization and institutionalization of Veterans Administration activities in the past.

If Bradley and Hawley act as we think they will, doctors in private practice will face a real challenge. If that challenge is met, disabled veterans will get better care and the expansion of governmental facilities can be minimized.

#### MORE TRAINEES IN BEDSIDE CARE URGED BY RED CROSS

Officials of the American Red Cross are requesting physicians to encourage laymen to enroll in a Red Cross Home Nursing Course, believing that it is necessary that at least one member of every family be trained in the simpler techniques of bedside care, especially during this period of overcrowded hospitals and a shortage of professional nurses.

The course is designed to provide instruction and supervised practice in carrying out simple nursing procedures such as taking a temperature with a clinical thermometer, keeping the patient comfortable in bed, giving a bed bath, giving medications and simple treatments prescribed by the physician, serving a tray, including proper selection of foods for the invalid, improvising sick-room equipment from materials which are readily at hand, and other nursing skills and techniques. It also includes instruction in the recognition of illness and the prevention of the spread of communicable disease.

The advantages to the physician of having someone with this training in the home where his patient must be cared for, until the services of a graduate nurse may be secured, are obvious.

Local Red Cross chapters everywhere are presently accepting applications for Fall classes.

#### PRESENT MENTAL HYGIENE PROGRAM ONLY A GOOD BEGINNING

Mental and personality disorders have caused the rejection of more Selective Service registrants and accounted for more disability discharges from the armed forces than any other defects, the Medical Division and the Division of Research and Statistics of the National Selective Service Headquarters reported recently.

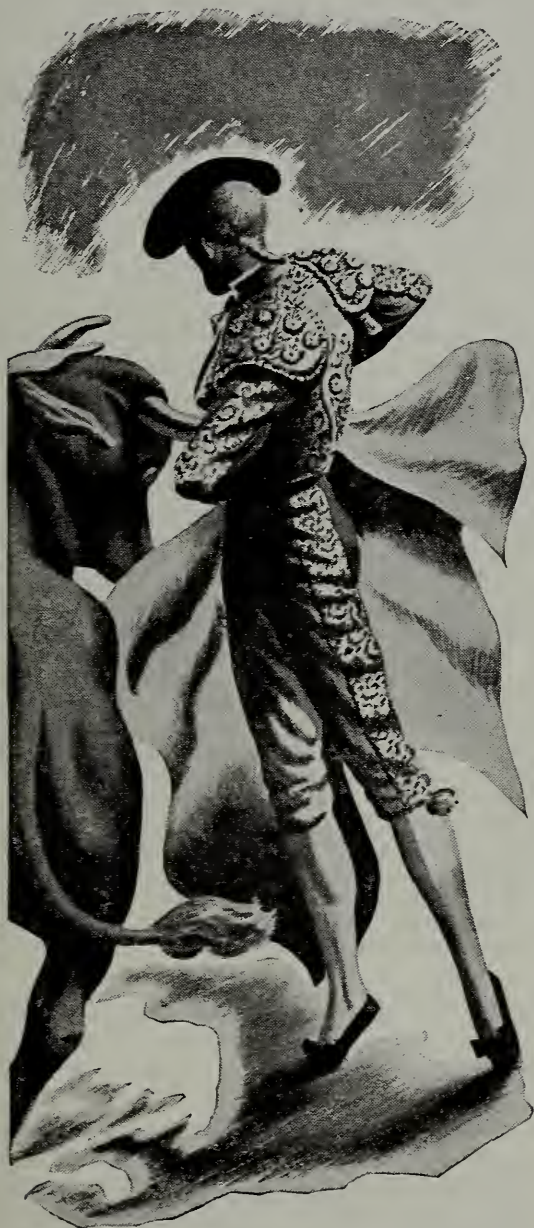
On January 1, 1945, an estimated 801,700 or 17.8 per cent of the 4,493,000 registrants aged 18-37 in the rejected class were so classified because of mental and personality disorders, the report stated.

This situation means that there is a big job ahead for the medical profession and those engaged in the field of social science.

Ohio this year made considerable progress toward building up a sound mental hygiene pro-



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gram. However, much remains to be accomplished. Sixteen of the 21 legislative recommendations of the Governor's Committee on Mental Hygiene were enacted into law by the Ohio General Assembly. Several important recommendations were not enacted. These should receive attention in some way at an early date, especially appropriation of more money for preventive work.

Commenting on the present status of the mental hygiene program in Ohio, the Ohio Institute in its official publication said:

"Altogether, the legislative session just closed has accomplished more for the care and treatment of persons suffering from mental illness and deficiency than the combined acts of legislatures for many years past. What has been done will enable Ohio to improve its service greatly; but it will not put Ohio in the top group of progressive states in this field. Owing to the accumulation of needs over a long period, the relatively large building program now possible will provide less than half of the facilities considered by the Governor's Committee to be 'immediate and urgent'. The next General Assembly must therefore be prepared to make further large appropriations both for additional facilities and for adequate operating expenses.

"In translating into terms of bed space the \$3,360,664 for rehabilitation of existing facilities and the \$15,000,000 for new construction, it must be remembered that all of the first item goes into rehabilitation of service units or of structures already occupied to the maximum and beyond, and that portions of the second item are designated for the acquisition of land or for providing dining rooms, living quarters for employees, recreational equipment, power plants and other facilities which must keep pace with the enlargement of bed space. Therefore, while the amount of money appropriated is approximately one-half of the amount recommended, the resultant number of beds will fall considerably short of one-half of the number needed."

## PREVENTIVE AND SOCIAL ASPECTS OF MEDICINE EMPHASIZED

Commenting on the expansion of the Department of Preventive Medicine and Public Health at Western Reserve University, Dr. James A. Doull, professor of Hygiene and Public Health and head of that department, made some observations which should not be ignored by medical students now in training and those who will enter medicine in the future. In fact, his advice on the future of medical practice also should be followed by physicians now in practice, resulting in many of them taking refresher work which will better prepare them for new conditions and problems which will arise.

Said Dr. Doull:

"Students preparing for the medical profession must learn what preventive services the doctor will be able to render to his patients and their families. Preventive medicine will not have to do merely with the prevention of infectious diseases, but also with the correction of defects in children, with the provision of adequate nu-

trition, the prevention of occupational hazards, the early detection of chronic diseases such as cancer and the diseases of the heart, and the efforts to correct behavior defects in childhood.

"Social aspects of medicine and especially community organization of medical personnel and facilities should be emphasized in the curriculum. Students entering the study of medicine in 1945 should be at the height of their medical careers between 1960 and 1980. They will be concerned with the older population; geriatrics will be more important to most of them than pediatrics. Their problems can not be predicted in detail, but it is certain that the mental and physical disabilities which will be encountered, can not be solved by the medical profession alone. The doctor must be taught to use fully the ancillary professions of dentistry, nursing and social work and the many agencies created by society, such as special schools, health museums and other institutions for the promotion of health."

## HERE AND THERE WITH THE INQUIRING REPORTERS

Senator Taft of Ohio, chairman of the Senate's Republican Steering Committee, has offered a program as the Republican version of the job which Congress faces. Included is a proposal, according to the United Press, for a coordinated program of social welfare legislation dealing with public housing, public health, public education, old age pensions, public works, and extension of unemployment compensation.

Taft is quoted as emphasizing that the social welfare program "should place the initiative and operation in every case in the state and local governments so that these activities are not Federalized". Also he is quoted as saying: "It should avoid delegation of power to Federal administrative agencies by prescribing definite standards and directions in the statutes."

Taft also said the public health bill, while it should extend Federal aid to build hospitals, expand public health services, and supply medical aid to low-income groups, should not be "based on socialized medicine or on any overall compulsory insurance plan as proposed in the Murray-Wagner-Dingell Bill."

\* \* \*

At a recent meeting in Chicago, the Executive Council of the American Federation of Labor took action urging the passage of the Wagner-Murray-Dingell Bill.

Among the major legislative issues on the "must" list of the C.I.O. Political Action Committee is the Wagner-Murray-Dingell Bill, according to a recent announcement from the C.I.O. Washington headquarters.

\* \* \*

Dr. Mary B. Spahr, who has practiced under many kinds of medical care plans—prepaid, post-paid and free under government control—takes the hide off the Wagner Bill in an article, "The Doctor Looks at State Medicine", in the July 21 issue of *The Saturday Evening Post*. Read it. She states "we doctors will favor no plan until we are convinced that it will advance the well-



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- . . . may be used either complemental to or entirely in place of human milk . . .
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FOR these reasons many physicians prescribe Baker's Modified Milk regularly. They have learned that in many cases when other formulas have failed, Baker's can be depended upon to provide what the baby needs.

Doctors who prescribe Baker's regularly will tell you they favor it because of its wide application—most feeding cases make better progress, require fewer adjustments. These, too, are reasons why Baker's is extensively used in hospitals.

And mothers like to feed Baker's Modified Milk because it is convenient and economical to use—there's only one thing to do: dilute to prescribed strength with water, previously boiled.

Baker's is well supplied with the nutritive elements for normal growth, and fortified with 7 dietary essentials, including liberal protein content (60% more than human milk).

Baker's Modified Milk is advertised only to the medical profession, and feeding instructions are supplied to physicians and hospitals only. Why not prescribe Baker's for your next feeding case?

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Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B<sub>1</sub> and D. Not less than 400 units of vitamin D per quart.

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being of our patients" and that "there are many alternatives to the Wagner Bill which will confer all the benefits possible without paralyzing medical practice".

\* \* \*

While Britain's election gave proof of a sharp swing of British public opinion to the left, American public opinion during recent years has moved in the opposite direction—toward the right, according to George Gallup and his American Institute of Public Opinion. He cites figures released August 4, based on recent polls, to substantiate this observation. We may know soon whether Dr. Gallup is on or off the beam.

\* \* \*

In an editorial, "German Doctors Under Nazism", *Collier's Weekly* quotes Colonel Edward D. Churchill, Allied Mediterranean forces surgical consultant, as stating that Germany's handling of wounded was about 20 years behind the American procedure.

*Collier's* points out that "ruled by the politicians and browbeaten by Nazi gangsters, German medicine—on the strength of Colonel Churchill's findings at any rate—withered, and in due time the German armed forces paid, in the form of bigger death totals than they need have suffered". Concluding, the magazine said: "The lesson in the German experience seems clear enough. It is that there is no substitute for a free, bold and inquisitive medical profession, or for generously financed and expertly staffed medical research, carried on year in and year out. It is devoutly to be hoped that the lesson of the German medical collapse will not be lost on us."

\* \* \*

It is reported that President Truman wants to create a new Department of Health and Welfare in which would be consolidated all of the health activities of the Federal Government, including apparently those of the Children's Bureau, now in the Labor Department. Labor Secretary Schwollenbach is said to be in favor of the switch. Here's hoping—.

#### NARCOTIC PRESCRIBING BY PHONE PERMITTED ONLY IN EMERGENCIES

Strict adherence to the regulations governing the prescribing and dispensing of narcotics should be the aim of every physician. Unfortunately, some physicians either are ignorant of the regulations or wink at them, as evidenced by the rather unusual number of technical violations in Ohio during recent months.

According to Federal narcotic officials, the practice of some physicians in telephoning many of their narcotic prescriptions to druggists has led to many difficulties and abuses.

Under existing regulations the furnishing of narcotics pursuant to telephone advice of physicians is prohibited except in cases of bona fide

emergency. In such an emergency a druggist may deliver narcotics via telephone order only if the person delivering the narcotic is supplied with a properly prepared prescription before delivery is made and this prescription must be turned over to the druggist and filed by him.

For their own protection, and the protection of the druggist, and to aid narcotic officials in eliminating illicit traffic in narcotics, physicians should restrict orders for narcotics by telephone strictly to actual emergency cases.

#### PRACTICAL MEMORIALS FOR SERVICE MEN

Service men's memorials in the form of permanent establishments for the restoration of injured veterans, rather than stone and bronze monuments in public places, is the aim of the Baruch Committee on Physical Medicine founded in 1944 by Bernard M. Baruch with an endowment of \$1,190,000.

This suggestion is commendable, in our opinion. It should be brought to the attention of groups interested in memorial programs.

The Baruch Committee has just sent out to institutions and consultants all over the country a blueprint of an ideal war memorial. The print shows the plans for buildings, equipment and staff required for such a center and plots the courses of treatment indicated for the restoration of maimed fighting men or injured war workers to useful activity. The blueprint proposes only the basic essentials of such a center, and is subject to variation to meet the special needs and limitations of large or little zones of population.

Communities generally should realize that permanent establishments erected for the benefit of their fighting men are much more fitting memorials to them than conventional monuments set up in public parks and squares. The Baruch Committee is encouraging communities to realize the validity of this, and that the funds customarily raised in communities for war monuments may well serve as nuclei for the more practical permanent centers.

After erection, and as time goes on, civilian patients, especially those injured in modern industry, may be sent to the centers by their personal physicians and surgeons, their care and treatment helping to meet expenses and overhead. The cost of treatment for military patients will of course be met by the Government, especially in the beginning. Ultimately such centers as the committee has in mind should be self-sustaining.

What is particularly hoped for by the Baruch Committee is that one of the tragic conditions following the first World War may be averted—the segregation of disabled fighting men in large veterans' hospitals remote from their homes.





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the

aged

patient

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of special value in the management of depression and anhedonia in the aged. Obviously, careful observation of the aged patient is desirable; and the physician will distinguish between the casual case of low spirits and a true and prolonged mental depression. The dosage should be adjusted to the individual case.

*Smith, Kline & French Laboratories, Phila., Pa.*

# In Memoriam

Stanton Kemble Crawford, M.D., Lakewood; University of Wooster, Medical Dept., Cleveland, 1888; aged 84; former member of the Ohio State Medical Association and the American Medical Association; died July 22. A native of Clarkson, Dr. Crawford practiced in Columbiana County until 1910 when he moved to Lakewood. He was formerly a staff member of Lakewood Hospital. Surviving are his widow, a brother and two sisters.

Russell LeRoy Guffey, M.D., San Francisco; Ohio State University College of Medicine, 1920; aged 52; died July 22. Formerly of Canton, Dr. Guffey practiced in San Francisco for 24 years. His mother, a sister and two brothers survive.

George Tracy Haverfield, Uhrichsville; Starling Medical College, Columbus, 1907; aged 63; member of the Ohio State Medical Association and the American Medical Association; died July 26. Dr. Haverfield practiced in Uhrichsville for 38 years. He was a former secretary and vice-president of the Tuscarawas County Medical Society. Dr. Haverfield was a member of the Masonic Order and the Buckeye Club. Surviving are his widow; two sons, Maj. William T. Haverfield, M.C., DeWitt General Hospital, Auburn, Calif., and Robert Haverfield, P.H.M.—1-c., in the Central Pacific; one brother and two sisters. A son, Ensign James Haverfield, lost his life in the Jap attack on Pearl Harbor, December 7, 1941.

John McClintock Higgins, M.D., Athens; Pulte Medical College, Cincinnati, 1893; aged 84; former member of the Ohio State Medical Association and the American Medical Association; died June 30. Health commissioner of Athens County for 37 years, Dr. Higgins retired in 1940. He was active in civic affairs in Athens, and was a charter member of Ohio Gamma chapter of Phi Delta Theta, at Ohio University. His widow, a daughter, three sisters and a brother survive.

Joseph L. Johnson, M.D., Columbus; Howard University College of Medicine, Washington, D.C., 1902; aged 72; died July 25. After several years as a medical examiner for the U. S. Bureau of Pensions, Dr. Johnson practiced medicine in Washington, Annapolis, Md., Columbus, and Rendville in Perry County, Ohio. As World War I drew to a close, he was appointed U. S. Minister to Liberia by President Woodrow Wilson, and served in that station for five years. Dr. Johnson was the Liberian representative at the Versailles peace conference. He was active in national Democratic politics and was president of many Negro organizations. Dr. Johnson was a

## DIED WHILE IN MILITARY SERVICE

Howard Dillon Maxwell, M.D., Alliance; Ohio State University College of Medicine, 1930; aged 42; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Aug. 12, at Fletcher General Hospital, Cambridge, where he had been a patient for 45 days. After practicing 11 years in Alliance, Dr. Maxwell entered the Medical Corps of the Army of the United States in 1942. He served overseas in New Guinea and the Philippines. Dr. Maxwell was hospitalized on Leyte and returned to the United States for further treatment. His widow, a daughter and his parents survive.

former president of the Board of Trustees of Wilberforce University. Surviving are a son, Dr. Walter J. Johnson, Washington, D.C., a daughter, a sister and two brothers.

Herman William Koerper, M.D., Columbus; Rush Medical College, Chicago, 1912; aged 57; member of the Ohio State Medical Association and the American Medical Association; died July 26. Associate professor of obstetrics at Ohio State University College of Medicine, Dr. Koerper practiced in Columbus for nearly 30 years. He took postgraduate work at the University of Vienna in 1920 and 1921, and was a first lieutenant in the Army Medical Corps during World War I. Dr. Koerper was consulting obstetrician at Mt. Carmel and University Hospitals. He was a member of the Medical Review Club, the Columbus Obstetrical and Gynecological Society and the First Congregational Church. His widow, two sisters and two brothers survive.

Frank Sheridan Lott, M.D., Columbus; Ohio Medical University, Columbus, 1901; aged 81; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 31. A life-long resident of Columbus, Dr. Lott had been surgeon for the Columbus Division of the Pennsylvania Railroad for 31 years and was founder and chief of staff of the old St. Clair Hospital. He was a member of the Masonic Order and Alpha Kappa Kappa. His widow and a son survive.

Van Newhall Marsh, M.D., Painesville; New York University Medical School, 1899, and University of Wooster Medical Dept., Cleveland, 1900; aged 69; member of the Ohio State Medical Association and Fellow of the American Medi-



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\*U. S. Summary of Vital Statistics, 1942.

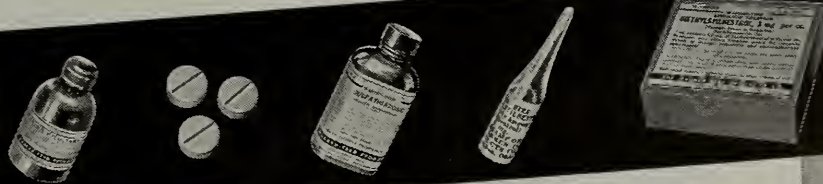
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cal Association; died July 25, in Ukiah, Calif. Dr. Marsh practiced in southern Ohio, Montana and Washington before locating in Painesville in 1916. Active professionally there for 29 years, he was a former president, chairman of the legislative committee and delegate of the Lake County Medical Society. Dr. Marsh also had represented the Ohio State Medical Association in the House of Delegates of the American Medical Association. He was head of Painesville's civilian defense organization and medical examiner for the local draft board. In failing health since last December, Dr. Marsh retired June, moving to California with his family. Surviving are his widow; two sons, Dr. John D. Marsh, Ukiah, Calif., and Lieut. Thomas P. Marsh, A.A.F., Germany; and three daughters.

**James McIlvaine Phillips, M.D.,** Columbus; University of Pennsylvania School of Medicine, Philadelphia, 1898; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died July 28. Following graduation, Dr. Phillips studied in London and on the Continent and demonstrated intubating as a method of combating diphtheria. He came to Columbus in 1901 to teach comparative pathology at Ohio State University. Dr. Phillips founded the Pasteur Institute in Columbus in 1911. There he did research work in allergies and manufactured vaccines. Dr. Phillips contributed articles on his findings to *The Journal of the American Medical Association*, the *American Kennel Gazette*, and the *Journal of Heredity*. In 1929 he retired from the practice of medicine, bought the Scioto Dog Kennels and continued his studies of hereditary traits. His most recent report appears in the current issue of the *Journal of Heredity*. Surviving are his widow and a daughter.

**Resin J. Pumphrey, M.D.,** Massillon; Cincinnati College of Medicine and Surgery, 1885; aged 83; former member of the Ohio State Medical Association, the American Medical Association and the American College of Surgeons; died July 20. Dr. Pumphrey retired because of ill health and moved to Lakeworth, Fla., about five years ago. He had practiced in Flushing for 10 years and in Massillon for 45 years. His widow and two sons survive.

**John William Ridenour, M.D.,** Ada; Eclectic Medical College, Cincinnati, 1899; aged 77; died July 10. After a few years in Mendon, Dr. Ridenour opened an office in LaFayette in 1904, remaining there until he located in Ada in 1936. He was a member of the Masonic Order and the Methodist Church. His widow, a daughter and a sister survive.

**Walter Black Rogers, M.D.,** Cleveland; Johns Hopkins University School of Medicine, Baltimore, 1910; aged 62; member of the Ohio State

Medical Association and Fellow of the American Medical Association; died July 12. Assistant clinical professor of surgery at Western Reserve University School of Medicine, Dr. Rogers had practiced in Cleveland for 30 years. During World War I, Dr. Rogers was in France with the Lakeside Unit as a major in the Army Medical Corps. He retained his commission in the Reserve Corps and reached the rank of lieutenant-colonel. Dr. Rogers was a member of Beta Theta Pi and Nu Sigma Nu. Surviving are his widow, a daughter, a son, his mother, a sister and a brother.

**Edward Sturgis Rutledge, M.D.,** Johnstown; Ohio Medical University, Columbus, 1897; aged 82; died July 18. Dr. Rutledge practiced in Johnstown for 40 years, and previously was located in Fredonia for eight years. He was a member of the Masonic Order and the Eagles and Knights of Pythias Lodges. His widow, three sons, three daughters and a sister survive.

**Albert F. Schwenke, M.D.,** Rockbridge; Starling Medical College, Columbus, 1889; aged 81; died June 3. Dr. Schwenke practiced at Baltimore and Rockbridge for many years. He was a member of the Lutheran Church. His widow and a son survive.

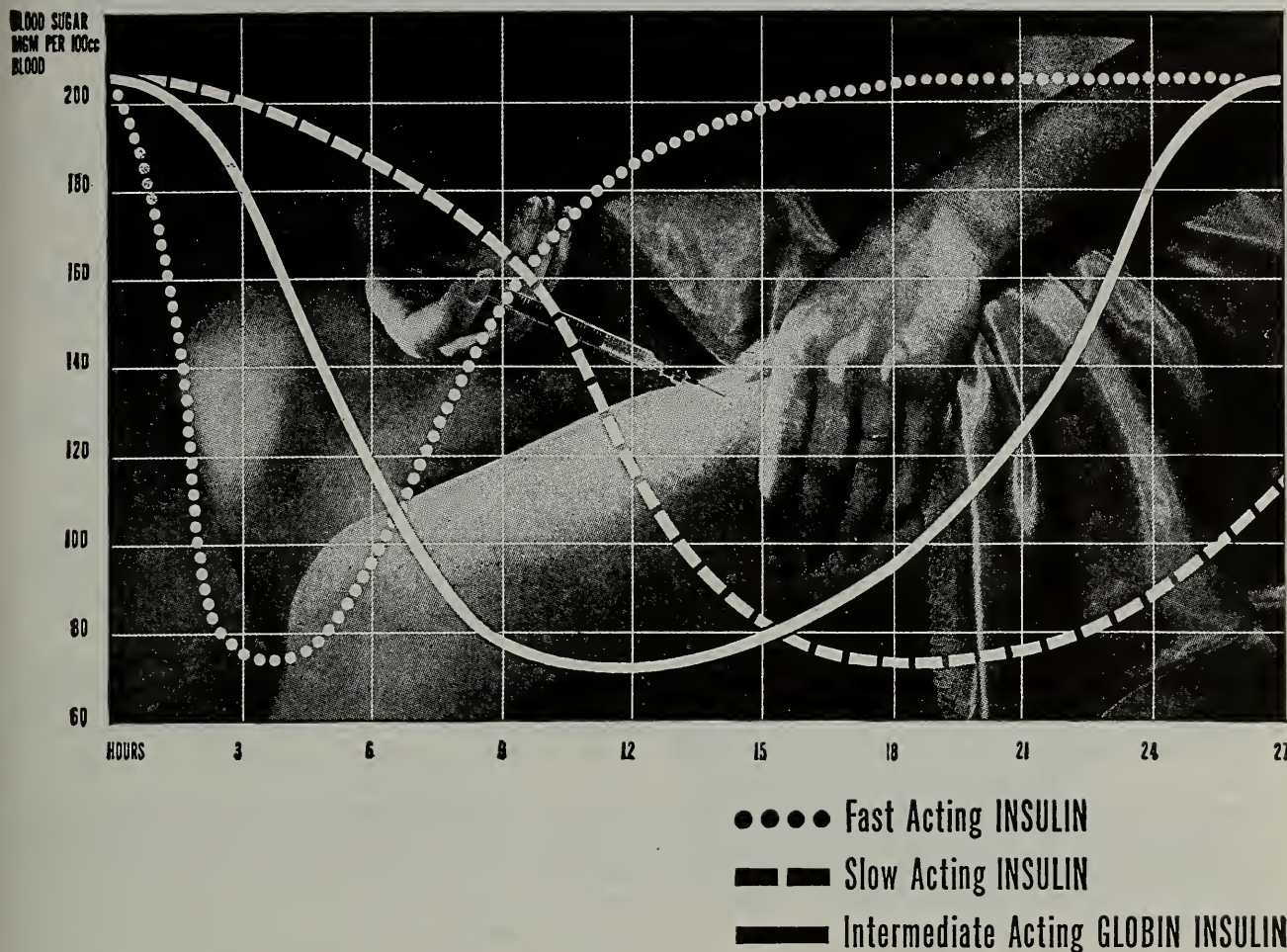
**Samuel Gordon Sloan, M.D.,** Elmore; University of Toronto Faculty of Medicine, 1924; aged 47; member of the Ohio State Medical Association and the American Medical Association; died July 3. A native of Ontario, Dr. Sloan served with the Canadian Expeditionary Forces during World War I. He had practiced in Elmore for 20 years and was a former secretary of the Ottawa County Medical Society. Surviving are his widow, two sons and a brother.

**Clement Dare Smedley, M.D.,** Youngstown; Medical College of Ohio, Cincinnati, 1903; aged 70; died July 8. A native of Hamilton, Dr. Smedley practiced in St. Bernard for several years. Following service in the Army Medical Corps during World War I, he located in Youngstown. Surviving are his widow, a son and a brother, Dr. A. L. Smedley, Hamilton.

**Walter John Smith, M.D.,** Columbus; Medical College of Ohio, Cincinnati, 1902; aged 67; former member of the Ohio State Medical Association and the American Medical Association; died Aug. 16. Dr. Smith was chief of the Division of Communicable Diseases, State Department of Health, of which he had been a staff member for 15 years. He was a captain in the Army Medical Corps during World War I. Dr. Smith was a member of the Masonic Order, the Odd Fellows Lodge and the Presbyterian Church. A son and two sisters survive.

**Frank Curtis Titus, M.D.,** Toledo; Illinois Medical College, Chicago, 1903; aged 68; member





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of the Ohio State Medical Association, the American Medical Association and the American Urological Association; died July 14. Dr. Titus practiced in Toledo for 39 years. He was a member of the Masonic Order and the Church of Christ. During World War I he was a lieutenant in the Army Medical Corps. His widow survives.

**James Samuel Wolfstein, M.D.,** Cleveland; University of Michigan Medical School, Ann Arbor, 1922; aged 47; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; Diplomate, American Board of Obstetrics and Gynecology; died July 27. A veteran of World War II, Dr. Wolfstein practiced in Cleveland for 20 years. While a major in the Army Medical Corps, he became ill with pneumonia, and was given a discharge in Feb., 1944. Dr. Wolfstein returned to private practice but became ill again early this year. His widow, his mother, a son, a sister and a brother survive.

### Activities of County Societies

#### ADAMS

Dr. Sam Clark was host to the members of the Adams County Medical Society and their families, at a chicken dinner, August 15, at the Knights of Pythias Hall, Cherry Fork. A general discussion of problems of medical organization and medical subjects followed.—Hazel L. Sproull, M.D., secretary.

#### CLINTON

A well-attended meeting of the Clinton County Medical Society was held at the General Denver Hotel, Wilmington, August 7. There was a roundtable discussion of the comparative use of sulpha drugs and penicillin. Dr. Richard Bath reported on the progress of the sale of stock in Ohio Medical Indemnity, Inc.—R. W. DeCrow, M.D., secretary.

Crestline—Dr. J. B. Moses celebrated his 50th anniversary as a practicing physician here on July 20.

### Material for 84 Broadcasts Offered by A. M. A. to Local Societies

The Bureau of Health Education of the American Medical Association now has available an additional series of electrically transcribed radio programs for use by local medical societies or by local health agencies with the approval of the local medical society. Entitled, "Guardians of Your Health", it consists of interviews and roundtable discussions featuring 33 public health authorities. The theme of the series is medical and public health cooperation for the better health of the nation. There are 13 broadcasts. Participants include Dr. Carl A. Wilzbach, health commissioner of Cincinnati, and Dr. Lester Taylor, Cleveland.

With the addition of these new transcriptions, this important and growing service of the Bureau of Health Education now offers a medical society seven series, a total of 84 broadcasts, enough to keep a medical society on the air weekly for almost two years.

"Medicine Serves America" deals with medical progress. "Live and Like It", a dramatized series, considers the everyday health problems such as weight control, sleep, prompt medical care and superstitions. "Before the Doctor Comes" consists of informal question-and-answer discussions with doctors about common symptoms occurring in the family. There is a series of 12 programs called "Dodging Contagious Diseases". For local societies wishing to remain on the air through the Summer, 12 transcriptions are available under the title "Keep Cool", dealing with Summer problems such as sun tan, swimming, bugs, poison ivy and hay fever. "More Life for You", in which 24 medical and surgical authorities are interviewed, considers the health problems of middle life.

The platters are available on loan by application to the Bureau of Health Education, 535 North Dearborn St., Chicago 10. There is no charge to the local group except payment of return shipping charges. The local societies must make all local broadcasting arrangements.

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# WAR NOTES

An AP war correspondent was hospitalized because his light American jeep lost an argument with a heavy Russian truck, and thus we learn that an Ohio physician, Capt. Raymond L. Shilling, Ashland, is on the staff of the first American hospital (113th Evacuation Hospital) to operate in Berlin. Describing his 15-day experience as a patient in the hospital, Louis P. Lochner has this to say in a news dispatch: "I've seen many evacuation hospitals but have found none so well equipped, both with medical facilities and operating room equipment, despite the fact that the hospital must content itself with a German building . . . My right eyelid was thoroughly lacerated. Capt. Raymond L. Shilling did such an artistic job of stitching and cross-stitching that it looks normal again. He also treated my eyes to eliminate certain effects of the injury and to restore completely my vision."

\* \* \*

Ohio has sent more than 3,535 registered nurses into the Army and Navy service since Pearl Harbor, according to a recent announcement of the Ohio State Nurses' Association.

\* \* \*

Col. Marshall M. Best, Xenia, is home on a 30-day leave, after nearly three years in the E.T.O. Late in 1944 he was awarded the Bronze Star for meritorious service in connection with military operations from April 18 to Oct. 31, 1944. At that time he was Ninth Air Defense Command surgeon.

\* \* \*

Lt. Comdr. William B. Faircloth, Zanesville, is medical officer aboard a large naval transport which has participated in actions at Tinian, Peleliu, Leyte, Luzon, Saipan and Iwo Jima.

\* \* \*

A new tour of duty, via a fine new hospital ship, has taken Lt. Comdr. H. Vern Sharp, Akron, "away from buzz bombs to the kamikazi". Comdr. Norman J. Birkbeck, Dayton, is a shipmate.

\* \* \*

Lt. Comdr. B. L. Johnson, Deshler, on duty with a Fleet hospital in the Philippines, recently had a pleasant visit with Major Gerald H. Dennis, Dayton.

\* \* \*

Lt. Comdr. P. E. Kellogg, Ashland, has this to say from aboard a ship out in the Pacific: "I doubt that I will ever again complain that Ohio Summers are hot. I used to think that prickly heat was a minor disturbance which Johnson's

Medical officers who are changing stations would be doing the State Headquarters Office a great favor by notifying us promptly of their new address. Many of those who are being returned home for reassignment have requested that mailing of their copies of The Journal be held up until they know their new location. This thoughtfulness saves a lot of unnecessary work for the office and postal employees. We want every member in the service to get his copy of The Journal promptly and regularly. That can be accomplished if our mailing list is kept up to date.

Baby Powder would cure. I know differently now. I used to think also that the Officers Club was established during the second wave, but I found out that after spending two months on board without stepping foot on dirt, that this isn't so. I spent two afternoons late in March with Lt. Comdr. Marvin B. Goldstein, Youngstown, who was stationed at that time in Northern New Guinea. We started moving west soon after that, and when we dropped anchor, all agreed that this is close enough."

\* \* \*

Lt. (j.g.) S. E. Burkhart, Cleveland, who was aboard a ship which was lost in action at Okinawa, is now on duty at the U. S. Naval Barracks, Tampa, Fla. His senior medical officer is Lt. James E. Slivka, Cleveland.

\* \* \*

Comdr. Drew L. Davies, Columbus, base medical officer on an island in the Pacific, reports "swell bull sessions" with Comdr. Paul L. Yordy, Dayton, recently assigned there.

\* \* \*

State-side changes of address: Capt. A. C. Wyker, Columbus, Crile Gen. Hosp., Cleveland; Lt. Sam Tetelman, Cleveland Heights, P.O.E., Charleston, S. C.; Maj. Louis S. Zwick, Wadsworth, Army School of Roentgenology, Memphis, Tenn.; Maj. Theo. A. Cross, Cleveland, Sta. Hosp., Camp Campbell, Ky.; Capt. C. G. Chamberlin, Cleveland, Hammer Field, Fresno, Calif.;



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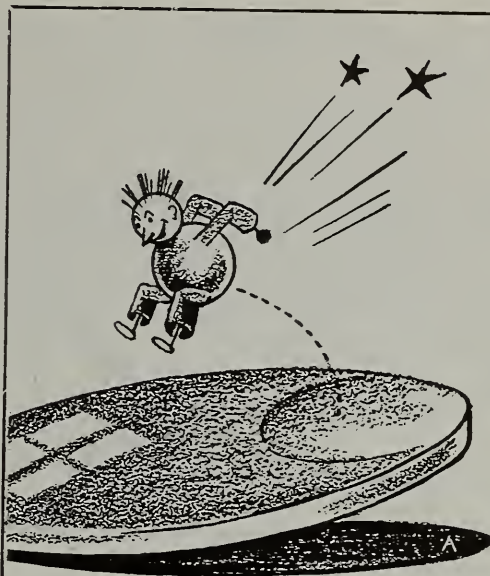
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Capt. Henry A. Long, Hamilton, Reg. Hosp., Ft. Sam Houston, Tex.; Capt. W. R. Liebschner, Deshler, A.A.F., O.R.D., Greensboro, N. C.; Lt. Henry P. Koehler, Findlay, U. S. Naval Hosp., Oakland, Calif.; Lt. Thomas S. Jenike, Cincinnati, U. S. Naval Auxiliary Air Facility, Sanford, Maine; Lt. D. L. Jacobs, Cincinnati, Lawson Gen. Hosp., Atlanta, Ga.; Lt. H. H. Insel, Lorain, U. S. Naval Hosp., Philadelphia, Pa.; Lt. Col. Burton E. Hyde, Troy, 210th Sta. Hosp., Ft. Lewis, Wash.; Capt. David L. Hirst, Miamisburg, Camp Atterbury, Ind.; Capt. Jack Greenfield, Cincinnati, Sta. Hosp., Camp Campbell, Ky.; Maj. Robert F. Corwin, Dayton, A.A.F., O.R.D., Greensboro, N. C.; Capt. D. R. Bieser, Dayton, 120th Evac. Hosp., Camp Polk, La.; Capt. Peary B. Berger, Englewood, Nichols Gen. Hosp., Louisville, Ky.; Lt. Lloyd J. Barson, Van Wert, Reg. Hosp., Camp Bowie, Texas; Capt. Robert E. Ballard, Lakewood, Dept. of Patients, Percy Jones Gen. and Conv. Hosp., Battle Creek, Mich.; Maj. R. E. Tyvand, Dayton, McCaw Gen. Hosp., Walla Walla, Wash.; Lt. Col. Geo. A. Tischler, Cleveland, Fletcher Gen. Hosp., Cambridge; Capt. J. G. Rosenbaum, Brecksville, Sta. Hosp., Hamilton Field, Calif.; Capt. Wm. K. Romoser, Columbus, P.W. Camp, Camp Rupert, Idaho; Capt. Paul E. Reading, Painesville, 663rd Clearing Co., Camp Swift, Texas; Maj. Elmer C. Loomis, Dayton, A.A.F., O.R.D., Greensboro, N. C.; Col. Phillip P. Pease, Chardon, Sta. Hosp., Seymour-Johnson Field, Goldsboro, N. C.

\* \* \*

Capt. Fred B. Hapke, Troy, is with a field hospital unit which is now operating two small hospitals for the 14th Air Force somewhere in China.

\* \* \*

Having just finished an assignment servicing P.O.W. stockades in the Rhineland around Remagen, an area taken over by French forces, Capt. D. H. Goodman, Cleveland, with the 62nd Field Hospital, expects to move back into France to help take care of American forces at an assembly area.

\* \* \*

Capt. Louis J. Tilton, Frazeysburg, overseas for over two years, including 18 months with the Third Armored Division and since March, 1945, with the 185th General Hospital in England, has been home on leave following temporary duty as medical officer on a ship returning liberated American prisoners of war to the States.

\* \* \*

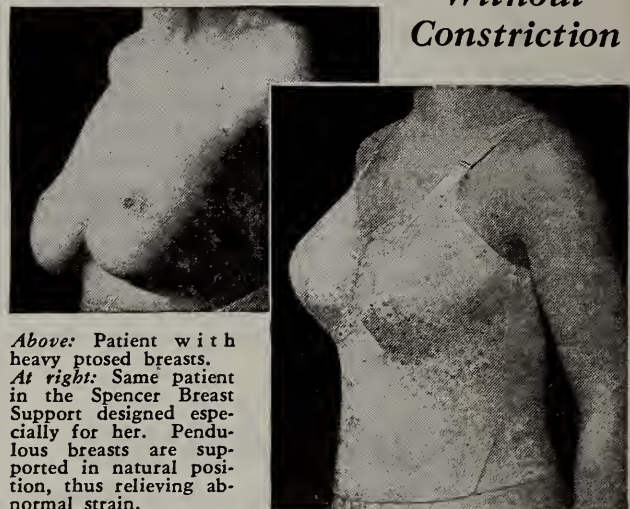
After 18 months overseas, Maj. A. C. Ormond, Zanesville, has been assigned to the staff of Fletcher General Hospital, Cambridge.

\* \* \*

Moved up from Australia, Comdr. H. P. Worstell, Columbus, is living in a tent on the beach of one of the Philippine Islands, where he is base medical officer, with three dispensaries in

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his "diocese". Maj. Jack A. Dillahun, O.S.U. '40, who practiced in Piedmont, Ala., before he entered the service, is pathologist in a nearby Army hospital. Dr. Worstell "had a couple of beers" with Comdr. Harry Sage, also of Columbus, early in July.

\* \* \*

Discharged from the Department of Patients, Crile General Hospital, Cleveland, Capt. Morris Wilderom, Medina, has been placed on limited service at Camp Breckenridge, Ky.

\* \* \*

Maj. Trent W. Smith, Columbus, has been home on leave, after over two years at an air base in Brazil.

\* \* \*

Pathologist for the past 18 months at a large naval hospital on a Pacific Island, "with the kind of climate that the California Chamber of Commerce dreams about", Comdr. Max Shaweker, Dover, anticipates a change of duty soon to the U. S. Naval Hospital, Great Lakes, Ill.

\* \* \*

Senior medical officer on an A.P.A., Lt. Thomas W. Tucker, Cincinnati, has been on two major operations, Iwo and Okinawa.

\* \* \*

Writing from Bad Nauheim, Germany, with the 105th Evacuation Hospital, Capt. Carl R. Damon, Mansfield, sends in a stock subscription for Ohio Medical Indemnity, Inc., and reports a recent enjoyable leave on the Riviera.

\* \* \*

Maj. R. M. Bartlett, Akron, promoted recently, is with the 91st Field Hospital in Luzon.

\* \* \*

Engaged in the evacuation of patients from overseas to the continental United States, with the 620th Med. Hosp. Ship Platoon, Capt. James E. Rose, Sabina, has been in both theaters of operation, with the added pleasure of visiting the mainland frequently.

\* \* \*

Capt. Frederick W. Kaylor, Bellefontaine, is in Laon, France, with the medical detachment of the 775th F. A. Bn.

\* \* \*

Maj. Paul G. Meckstroth, New Knoxville, Auglaize County, was heading homeward when he wrote late in July, from the assembly area in the vicinity of Reims, France, where he was awaiting redeployment. He had traveled through Belgium, Luxembourg, ending up at the Elbe River, near Chemnitz, Germany.

\* \* \*

More state-side locations: Capt. Paul D. Meyer, Cleveland, Fletcher General Hospital, Cambridge; Lt. Comdr. S. A. Myers, Youngstown, U. S. Naval Hospital, Springfield, Mass.; Lt. R. C. Novatney, Elyria, U. S. Naval Air Station, Miami, Fla.; Lt. R. L. Piercy, Youngstown, Sta. Hosp., Camp Roberts, Calif.; Lt. R. S. Rosewater, Lakewood,

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### Highlights for October

- ★ CHEMOTHERAPY IN OTOLARYNGOLOGY  
—Wisconsin Medical Journal
- ★ PHYSICAL MEDICINE IN THE REHABILITATION OF PATIENTS WITH WAR NEUROSES  
—Archives of Physical Medicine
- ★ SURGICAL EXPERIENCES WITH ULCERATIVE COLITIS  
—Surgical Clinics of North America
- ★ THE MEDICAL TREATMENT OF BILIARY TRACT DISEASE  
—The Illinois Medical Journal

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\* \* \*

Maj. Frederick W. Clement, Toledo, chief of anaesthesia at the Biltmore unit of the A.A.F. Regional and Convalescent Hospital, Coral Gables, Fla., has been retired from active duty status and will resume his practice in Toledo. In the service for three years, Maj. Clement was previously chief of anaesthesia in A.A.F. hospitals at Greensboro, N. C.; Atlantic City, N. J.; and Bowman Field, Ky. He was a medical officer in the British and Canadian armies for six years during World War I.

\* \* \*

Ottawa Park, Toledo, has been approved by the U. S. Veterans Administration as the site of a \$3,000,000, 400-bed tuberculosis hospital. Plans to convert the veterans' general medical hospital at Brecksville to a tuberculosis facility have been abandoned. However, the Brecksville hospital's 413-bed capacity will be enlarged by 180 beds at a cost of \$1,200,000.

\* \* \*

From Buck Private to Lt. Col. in about four years—sounds like the Air Corps, but it actually happened to Dr. Sander Cohen, a Cincinnati physician. Immediately after Pearl Harbor, Dr. Cohen applied for a commission in the Medical Corps, but was rejected because of his height, which was considerably under Army specifications. When the University of Cincinnati Unit—the 25th General Hospital—was formed, he tried once more, and again was rejected on physical grounds. Following this, his local draft board inducted him and he was a private for 90 days, after which he was commissioned a 1st Lt. by the Surgeon General. The quality of his service is attested by his promotions. Lt. Col. Cohen has been in France for some time with the 40th General Hospital.

\* \* \*

Capt. Howard H. Minor, Steubenville, now at Selman Field, Monroe, La., is co-author of a paper entitled "Roentgen Demonstration of the Semilunar Cartilages of the Knee", published in the May, 1945, issue of *The American Journal of Roentgenology and Radium Therapy*.

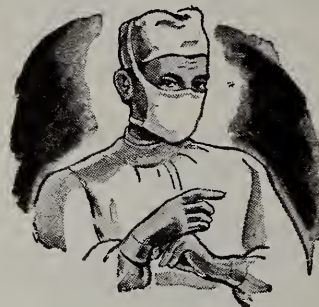
\* \* \*

Lt. Col. Wm. F. Lovebury, Columbus, recently won the Central Base Command Officers' Golf Championship with a 54-hole total of 228 while playing the Waialae Country Club course.

\* \* \*

Lt. Comdr. Wm. F. Lyons, Coshocton, had an interesting seven months in the West Carolines as medical officer and military governor for 400 native Micronesians, while on the staff of the

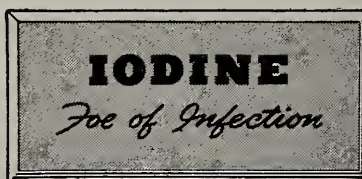
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island command. From there he went to Hawaii for six weeks in a base hospital. Dr. Lyons is now executive officer for a 250-bed hospital in the West Pacific. Not a bad year's experience, but he'll be glad to come home on or about Jan. 6, 1946, when his 18 months of duty is completed in the Pacific area. Despite his wandering, "that *Journal*" has found him, he reports, though sometimes three months late—not bad, considering that three of his 1944 Christmas boxes have not yet arrived.

\* \* \*

According to the Public Relations Office, Headquarters, Air Technical Service Command in Europe, Col. Herbert B. Wright, Cleveland, recently received two honors in recognition of outstanding contributions to medical science during three years as an Air Force surgeon in the E.T.O. He was awarded the Legion of Merit by General Carl A. Spaatz, then Commanding General of the United States Strategic Air Force, and the French Flight Surgeons Wings by General Jean C. Clarc, Surgeon General of the French Air Forces.

\* \* \*

Col. Leonard G. Rowntree, Philadelphia, has retired as Chief of the Medical Division of the National Selective Service Headquarters after four and one-half years' service.

\* \* \*

After a year and one-half in England with the 159th General Hospital, Maj. William F. Hunting, Cincinnati, has been assigned to the Station Hospital, Camp Campbell, Ky., as chief of the Contagious Disease Section.

\* \* \*

Maj. John J. Gallen, Columbus, home after 38 months in the Southwest Pacific with the 37th Division, was married to Miss Winifred Kathryn Barnum at New Orleans, La., on Aug. 14. He was due to report at Camp Atterbury, Ind., for reassignment on Aug. 26.

\* \* \*

Columbus medical officers home from the E.T.O. on 30-day leaves and awaiting reassignment, include: Maj. John E. Martin, Capt. John P. Urban, and Capt. Robt. D. Myers.

\* \* \*

Maj. C. Edgar Northrup, McConnelsville, who was on duty with the Medical Recruiting Board in Ohio in 1942, is home on a 30-day leave after a year in the E.T.O. He was with a hospital unit attached to the Third Army.

\* \* \*

Medical officers who returned from the E.T.O. with the 95th Division included the following: Capt. C. Raymond Crawley, Mt. Healthy; Capt. Frank Hanrahan, Cleveland; Capt. Ormond

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Haynes, Marietta, and Capt. John Campbell, Cincinnati. They are now at Camp Shelby, Miss.

\* \* \*

Born in China, Lt. Col. Ben C. Houghton, Columbus, returned there for over two years as a medical officer with the Y-Force and later with the Chinese Combat Command. He is home now on a 30-day leave.

\* \* \*

Maj. Attilio D. Puppel, Ashley, has reported to the A.A.F. Redistribution Station No. 1, Atlantic City, N. J., after 33 months of service in the Mediterranean theater.

\* \* \*

Col. Russell J. Caton, Bucyrus, has been home on a 45-day leave after 38 months in the Pacific, where he supervised medical installations on various islands, the latest of which was Okinawa.

\* \* \*

Lt. Col. Joseph A. Ridgeway, Columbus, was recently awarded the Bronze Star Medal for "meritorious service in connection with military operations in England, France, Belgium and Luxembourg", as commanding officer of a medical detachment.

\* \* \*

Assistant chief of surgery of the 141st General Hospital near Divezes, England, for the past year, Maj. William E. Elliott, Alliance, related some of his experiences at a meeting of the Alliance Kiwanis Club. He was to report at Camp Crowder, Mo., for re-assignment.

\* \* \*

Lt. Col. Edwin M. Kennedy and Capt. Anthony M. Tanno, both of Cleveland, recently participated in a radio program produced at the 228th Station Hospital, Dorsetshire, England, which was transcribed over Station WJW, Cleveland.

\* \* \*

A United Press dispatch from Okinawa, describing battlefield treatment of combat fatigue, referred to Lt. Col. Oscar Markey, Cleveland, as one of the consultants in psychiatry there. He is attached to the Hdqrs. of the 10th Army.

\* \* \*

In a rice paddy, full of mud, on Luzon where it rains daily, is the predicament of Lt. Horace M. Leeds, Winchester, now with the medical detachment of a field artillery battalion.

\* \* \*

Lt. Col. William S. Keller, U.S.P.H.S. (R), Cincinnati, previously with the Office of Civilian Defense in Chicago, is now director of health, Ouachita Parish, Monroe, La.

\* \* \*

In Africa for 32 months, with the monotony of the shifting desert sands, Capt. R. J. Anzinger, Springfield, feels fortunate that he has been able to practice his specialty—internal medicine—

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ever since he has been in military service. He is now very busy in a 300-bed station hospital in the Cairo area. Capt. Anzinger prefers the Ohio to the Nile, and would rather see green grass than the Sphinx. His brother, Capt. Frank W. Anzinger, Springfield, is with the A.A.F. in India.

\* \* \*

Returned from the Philippines where he was with the 44th General Hospital, Maj. Wm. R. Hochwalt, Dayton, is now at Percy Jones General Hospital, Battle Creek, Mich.

\* \* \*

More new addresses in the United States: Col. G. P. Lawrence, Westerville, 650 Rush St., Chicago, Ill.; Lt. Col. Lester C. Thomas, Lima, 141st Gen. Hosp., Camp Crowder, Mo.; Lt. C. P. Somsel, Dayton, F.A.R.T.C. Hdqrs., Ft. Bragg, N. C.; Lt. Comdr. G. P. Sims, Columbus, U. S. Naval Hospital, Norman, Okla.; Capt. T. R. Shoupe, Findlay, England Gen. Hosp., Atlantic City, N. J.; Capt. E. W. Schilke, Springfield, Med. Det., 303 F.A.Bn., APO 445, Ft. Bragg, N. C.; Capt. A. P. Newman, Carleton, Mich.; Lt. Harry D. Morris, Cleveland, U. S. Naval Hosp., St. Albans, N. Y.; Lt. Frederick Goldman, Cincinnati, U. S. Naval Hosp., Norman, Okla.; Capt. Bernard Malasky, Cleveland Heights, 58th Rcn. Sqd., Weather, R.C.A.A.F., Rapid City, South Dakota.

\* \* \*

Maj. Herman G. Rubin, Akron, recently returned from the South Pacific Area, is now at Billings General Hospital, Ft. Benjamin Harrison, Ind.

\* \* \*

From out of the Pacific on the U.S.S. Okanogan (APA 220) Lt. Comdr. R. E. Pumphrey, Dayton, sends a note of appreciation for the interest the State Association has taken in its members in the service.

\* \* \*

Capt. Richard C. Miller, Dayton, is doing anaesthesia at the 23rd General Hospital, near Paris. He has been in the service almost three years, and has been overseas 15 months.

\* \* \*

Shortly after Capt. J. H. Geyer, Columbus, graduated from paratroop school, he went to the South Pacific with the 11th Airborne Division and is now in a rest camp in Southern Luzon, P.I. He feels fortunate that in his three combat jumps he got by with only a few scratches.

### Local Subdivisions Responsible

Local subdivisions are responsible for the expense of medical care and hospitalization of an indigent person who is wounded by a police officer while in the act of committing a felony, according to Opinion No. 361 rendered by Attorney General Hugh S. Jenkins, July 28.

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## WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### ALLEN

Mrs. H. L. Stelzer, president of the Woman's Auxiliary to the Academy of Medicine of Lima and Allen County, presents the following interesting report for the year 1944-1945. An average of 15 members were present at the monthly meetings. Programs were as follows: A talk on the article "Hospital Ship" from *Hygeia*; "Child Delinquency" by Miss Pfeiffer of the Probate Court; a program on Opera; a talk on "Rehabilitation"; reprints from *Hygeia* on Health; talk by a visiting nurse; book review; "Civilization and Disease" by Dr. Siegerist.

### LUCAS

The Lucas County Auxiliary is composed of 214 members, 43 of whom have husbands in the service. The Board of the Auxiliary has met every month, with one or two exceptions, in the Library of the Academy of Medicine for the transaction of business, but has continued the policy of having few meetings of the Auxiliary during the war. One of the most interesting meetings was a panel discussion on postwar regional planning for Toledo. During the past year the Auxiliary has donated to the Red Cross, sold \$325,000 worth of war bonds, and contributed outstanding work to the Library of the Academy of Medicine, reclassifying books and periodicals, furnishing material for the doctors and placing the Library on the exchange list.

### SCIOTO

Mrs. A. P. Hunt, president of the Auxiliary to the Hempstead Academy of Medicine, gave the following report for the past year. Membership 61, with 13 service wives. Majority of the meetings were held in members' homes. Two luncheons were enjoyed, one in honor of Mrs. Roswell S. Fidler, President of the Woman's Auxiliary to the Ohio State Medical Association, and the other had as guest speaker Dr. C. L. Ferguson, who gave an instructive talk on penicillin. Other programs consisted of Local Health Problems, by Dr. C. W. Wendelken; Juvenile Delinquency, by Judge Emory Smith; discussion of the Wagner-Murray-Dingell Bill; and two book reviews by Mrs. W. E. Gault. Many members worked with the Red Cross in various capacities, the Canteen being one of the Auxiliary projects. Contributions of money have been made to the Red Cross, Social Hygiene Committee, Crippled Children's Class at Grant School County Home, Salvation Army, Disabled War Veterans, Christmas Seal Fund, and to the nurses at General Hospital to purchase a demonstration doll. Tax stamps are saved for the crippled children. The children at the Scioto County Children's Home were given gifts. Funds for the above projects were ob-

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**OBSTETRICS**—Two Weeks Intensive Course Oct. 8.

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tained by having a rummage sale, bake sale, antique sale and by selling Christmas cards. This report does not show all that has been accomplished. The most important work has been the friendships made by working together, and it is due to this cooperation that the Auxiliary has been able to function so successfully.

#### STARK

Mrs. I. H. Behrenburg, president of the Auxiliary, reports the members have held five meetings, with average attendance of 45-60. A \$100 War Bond was purchased and \$150 contributed to the Red Cross. At a Christmas Tea gifts were collected to be distributed by the Visiting Nurses' Association. The programs were all interesting as well as stimulating.

Cambridge—Plans for a 150-bed community hospital for Cambridge and Guernsey County have been approved by the War Production Board. A special levy will be presented to the voters in the November election to assist in financing this project.

Dr. Christopher Leggo, formerly chief of the Division of Industrial Hygiene, State Department of Health, is on the medical staff of the Clinton Engineering Works, Oak Ridge, Tenn., much in the limelight lately as a manufacturing plant for atomic bombs.

#### CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line, payable in advance. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

**WANTED:** Resident physician, male or female, for sanatorium; salary \$3,000 per annum. Will sell interest in business to properly qualified physician. Write Stokes Sanatorium, Louisville, Ky.

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**PHYSICIAN WANTED:** To take over \$12,000 general practice; established 11 years; no other doctor in good town of 1,000; smaller towns nearby; good roads; all utilities and conveniences. Will rent office and residence or sell on terms agreeable to purchaser. If real estate is purchased no price asked for the practice, including all patients' records and office equipment. Present owner leaving because of allergic condition. J.A.T., care of Ohio State Medical Journal.

**WANTED:** Laboratory technician—preferably registered—in a university affiliated tuberculosis hospital. Salary dependent upon qualifications. Dunham Hospital, Price Hill, Cincinnati 5.

**FOR SALE:** Physician's hydraulic examination chair, all positions. Chair in good condition. Price \$50.00. Fremont Lewis, Leipsic, Ohio.

**WANTED:** Physicians; good salary; institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne State School, Fort Wayne 1, Indiana.

**WANTED:** To buy: "Atlas of Congenital Cardiac Disease", by M. E. Abbott. Write E. W. Miskall, M.D., East Liverpool.

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The local health commissioner, in transmitting the request of the attending physician, may contact the following persons by calling MAin 1265, and the extension number as given, or, after office hours, by calling home numbers as given: Dr. Roger E. Heering, Director of Health, Ext. 500, Home: LAwnedale 7916; Mr. J. E. Bauman, Assistant Director, Ext. 504, Home: FAirfax 4425; or Dr. Susan P. Souther, Chief of the Division of Child Hygiene, Ext. 506, Home: UNiversity 3615.

The University of Pittsburgh School of Medicine offers an orientation course in Clinical Allergy, under the sponsorship of The American Academy of Allergy, for five days, Oct. 1 to 5. The fee is \$40, with a special rate of \$10 for veterans, service men and residents. Registration for evening roundtable conferences only may be made by special arrangements. Inquiries should be addressed to William S. McEllroy, M.D., Dean of the School, Pittsburgh 13, Pa.

## NAMES ADDED TO MILITARY ROSTER

| Name              | City        | Rank               |
|-------------------|-------------|--------------------|
| Simon, Richard D. | Toledo..... | Lt. (j.g.), U.S.N. |

## WIN PROMOTIONS

| Name                  | City                   | Rank               |
|-----------------------|------------------------|--------------------|
| Angerman, Walter      | Wooster.....           | Major, U.S.A.      |
| Bartlett, Robert M.   | Akron.....             | Major, U.S.A.      |
| Beachler, John F.     | Piqua.....             | Capt., U.S.A.      |
| Bieser, Dietrich R.   | Dayton.....            | Capt., U.S.A.      |
| Bryant, Richard D.    | Cincinnati.....        | Lt. Comdr., U.S.N. |
| Campbell, John        | Cincinnati.....        | Capt., U.S.A.      |
| Cassidy, R. H.        | Columbus.....          | Lt., U.S.N.        |
| Crawley, Clarence R.  | Mt. Healthy.....       | Capt., U.S.A.      |
| Faller, Wm. W.        | Cleveland.....         | Capt., U.S.A.      |
| Fleming, John G.      | Cincinnati.....        | Lt. Comdr., U.S.N. |
| Geyer, Joseph Herbert | Columbus.....          | Capt., U.S.A.      |
| Gibson, James K.      | Tiltonville.....       | Major, U.S.A.      |
| Glover, Donald M.     | Cleveland.....         | Col., U.S.A.       |
| Hait, Louis           | Lorain.....            | Capt., U.S.A.      |
| Haynes, Ormond L.     | Marietta.....          | Capt., U.S.A.      |
| Hendricks, Anthony B. | Cincinnati.....        | Major, U.S.A.      |
| Hines, Harry K.       | Cincinnati.....        | Capt., U.S.A.      |
| Houghton, Ben C.      | Columbus.....          | Lt. Col., U.S.A.   |
| Johnson, Nicholas J.  | Youngstown.....        | Capt., U.S.A.      |
| Koehler, Joseph S.    | Dayton.....            | Comdr., U.S.N.     |
| Kotte, Robert H.      | Cincinnati.....        | Lt. Col., U.S.A.   |
| Mack, Joseph          | Canton.....            | Capt., U.S.A.      |
| Mallett, Dean W.      | Springfield.....       | Capt., U.S.A.      |
| Meyer, Wm. G.         | Columbus.....          | Major, U.S.A.      |
| Mielcarek, Paul A.    | Cleveland.....         | Lt. Col., U.S.A.   |
| Miller, Joseph M.     | Marion.....            | Major, U.S.A.      |
| Minelli, Anthony J.   | Cleveland.....         | Lt., U.S.N.        |
| Ridgeway, Joseph A.   | Columbus.....          | Lt. Col., U.S.A.   |
| Rowe, Peter           | Cleveland Heights..... | Lt. Col., U.S.A.   |
| Schaal, James A.      | Cincinnati.....        | Major, U.S.A.      |
| Smith, Trent W.       | Columbus.....          | Major, U.S.A.      |
| Start, Gwyn H.        | Toledo.....            | Major, U.S.A.      |
| Stewart, James V.     | Massillon.....         | Capt., U.S.A.      |
| Tanno, Anthony M.     | Cleveland.....         | Capt., U.S.A.      |
| Thompson, James E.    | Washington C.H.....    | Major, U.S.A.      |
| Tildes, J. H.         | Cleveland.....         | Lt. Comdr., U.S.N. |
| Van Epps, Herbert F.  | Dover.....             | Major, U.S.A.      |
| Wright, Jackson W.    | Cincinnati.....        | Major, U.S.A.      |

## New Field Army Secretary

Miss Hilda McGee, Cleveland, has been appointed executive secretary of the Ohio Division, Field Army, American Cancer Society, with headquarters at 1030 Euclid Avenue, Cleveland. A graduate of Mather College, Western Reserve University in 1922, Miss McGee obtained the degree of Master of Social Administration in the School of Applied Social Sciences at W.R.U. in 1929. Her experience includes about one and one-half years in secretarial work at W.R.U.; eight years as medical social worker at University Hospitals, Cleveland, and over seven years as director of the Medical Social Service Department of City Hospital, Cleveland. For the past six months Miss McGee has been executive secretary of the Cleveland chapter of the American Association of Social Workers.

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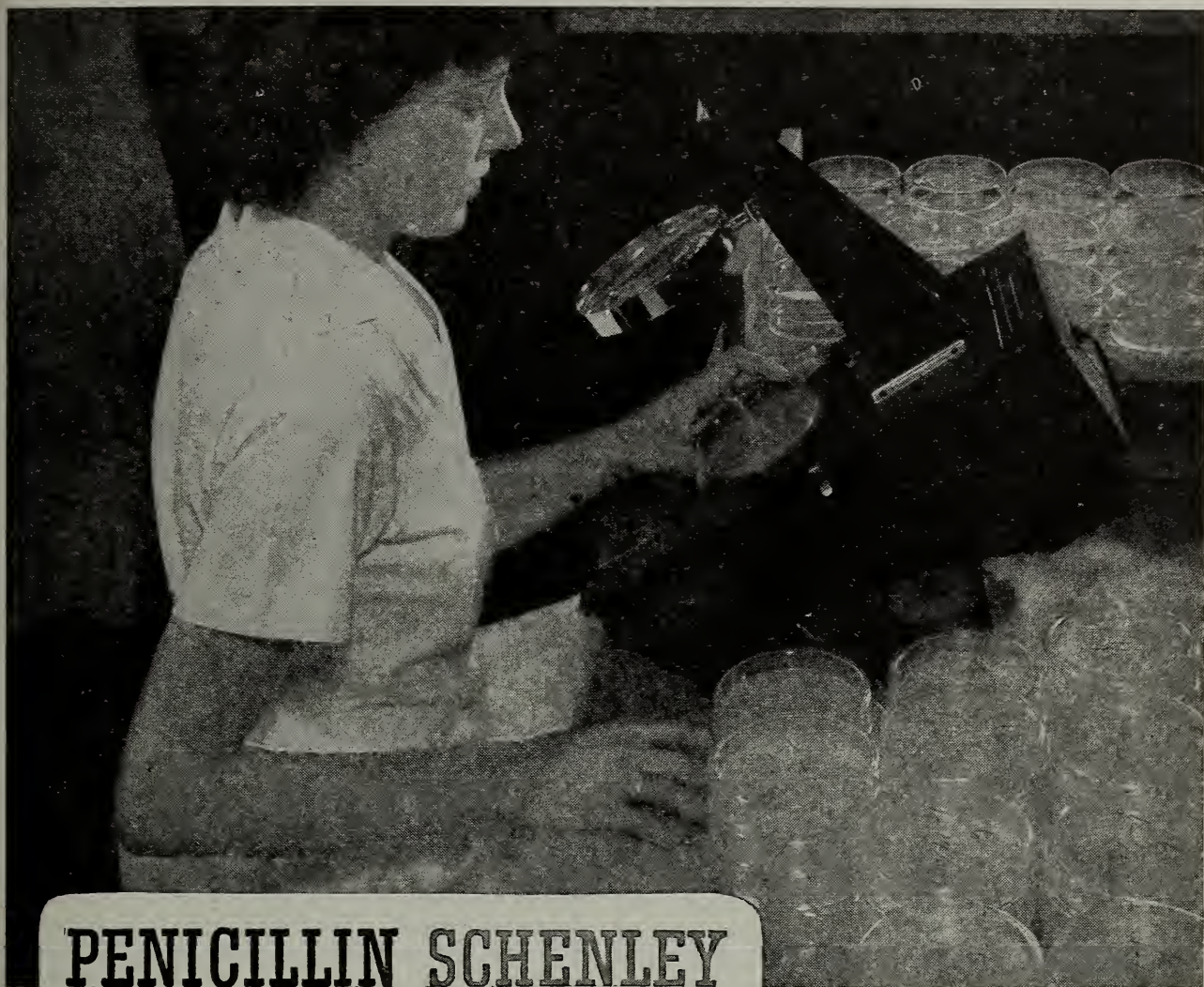
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## The Physician's Bookshelf

**The Preacher's" Voice**, by William C. Craig and R. R. Sokolowsky, M.D., (\$2.00. *The Wartburg Press, Columbus, Ohio*) is a book of great service to us physicians who do any public speaking. Last Spring I found an interesting appreciation on the part of physicians of public speaking. A group of active members of the Orleans Parish Medical Society in New Orleans have organized a section of that society which is also a chartered local of "The Toastmasters Club". Every week they meet to dine and practice speeches on the public relations of the profession. The result is that this county society has more than a score of members whom it can send out to speak and speak as it should be done, both as to material and delivery. More of us should do that, or, in lieu of it, each of us should study this book which explains the mechanics of the voice in a way that anyone can understand.

This book is unique in that it gives the key to understanding speech habits and presents the best way of overcoming the bad ones. The scientific facts concerned in successful public speaking, as determined by proper voice production, are presented in a clear, non-technical manner.

**The Music Is Gone**, by LeGarde S. Doughty, (\$2.50. *Duell, Sloan & Pearce, Inc., New York City*) is a novel of the deep south, the principal character of which is Dr. William Gray. Dr. Gray was of the tradition that medicine was an art offering an opportunity to serve humanity in a gentle, selfless way. His work and how he helped the children of the countryside make a lasting impression. The whole story is delightful reading.

**Authority In Medicine, Old and New**, by Major Greenwood, D.Sc., F.R.C.P., F.R.S., (\$0.40. *The Macmillan Company, New York City*) being the 1943 Linacre Lecture. It deals with an important question all too frequently raised in medicine.

**Poor Man's Doctor**, by Lewis R. Tryon, M.D., (\$2.75. *Prentice-Hall, Inc., New York City*) is the life story of a Pennsylvania Dutch doctor and bids fair to take a front position among the many popular books about physicians and their work. Its author, now in his 73rd year, has lived a full life as a country doctor and as a military surgeon. His reminiscences make good reading.

**Profitable and Necessarie Booke of Observations**, by William Clowes. Imprint at London by Edw. Bollefant for Thomas Dawson, 1596, being a facsimile reprint of the copy in the Henry E. Huntington Library with a general introduction by DeWitt T. Starnes and a medical introduction by Chauncey D. Leake, M.D. (\$6.00. *Scholars' Facsimiles & Reprints, New York City*). This

sets forth the author's observations on surgery and the treatment of venereal disease. Clowes was an excellent practical surgeon who wrote honestly in the vernacular from his own experiences. These writings, therefore, give us an idea of the standard procedure of the times. It is an interesting and valuable addition to any collection on military medicine and surgery.

**The Male Hormone**, by Paul DeKruif, (\$2.50. *Harcourt, Brace & Co., New York City*) is a bold and enthusiastic summary of the subject. The arrangement is more an empirical rationalization than a scientific treatise. A medical reporter of years' experience, who has run head on into medical conservatism many times, reports his own case. As he starts down the other side of the hill of life, he comes to have as much interest in the protection of his own vigor and the prolonging of his own life as heretofore he has shown toward those who die of hunger, of undulant fever and tularemia, tuberculosis, childbirth, and venereal diseases.

So, being a good reporter, he assembled 107 original scientific publications dealing with the male hormone. His interviews began with Dr. Herman N. Bundesen, a student of health, and then he put the question, "Can man's life be prolonged by chemistry?" to the major investigators and came up with the decision to take the hormone himself. This book goes well beyond the data and so may be offensive to the strictly scientific mind and the conservative physician. To all past 50 years of age, however, who are studying for personal reasons methods of prolonging life, this report deserves careful consideration.

**Penicillin and Other Antibiotic Agents**, by Wallace E. Herrell M.D., (\$5.00. *W. B. Saunders Co., Philadelphia*) brings us up to date on this timely topic. The book is by a consultant in medicine at the Mayo Clinic and gives us a full report on its use in all diseases.

**The Human Body**, by Logan Clendening, M.D., (\$4.00. 4th Revised Ed. *Alfred A. Knopf, Inc., New York City*) is one of the best expositions of the anatomy and physiology of the human body ever written for the layman. It will stand as a monument to a virile colleague who did so much to explain to the public what medicine is all about.

**Clinical Roentgenology of the Digestive Tract**, by Maurice Feldman, M.D., (\$7.00. 2nd Ed. *The Williams and Wilkins Co., Baltimore*) is designed as an aid for the X-ray diagnosis of the digestive tract for all who are interested. The book is complete and adequately informative. Its illustrations serve their purpose and it well deserves its success.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

October, 1945

No. 10

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## Prevention of Late Postpartum Morbidity\*

ZEPH J. R. HOLLENBECK, M.D.

TO attempt to discuss fully in one paper the subject of the prevention of the late postpartum morbidity is, I believe, an ambitious undertaking. It could well involve a series of discussions covering much of the field of obstetrics and gynecology. I have attempted to sift out some of the more common complaints or of the more common conditions which result in the morbidity, not of the puerperium especially, but of the late postpartum period which may be any time from forty days to forty years following the delivery.

It is not within the scope of this discussion to become involved in the causes and preventions of puerperal morbidity or of maternal death rates, except to note that the same factors materially contribute also to late morbidity; the complaints, the diseases or the conditions which are directly resultant from child bearing. I wish to point out merely, what I feel are some important steps which can be taken in the practice of obstetrics to at least reduce the incidence of post-pregnancy morbidity. We have all seen patients, over and over again, who have related to us the story that: "since my first baby was born, I have had backaches; I have had a discharge; I have had frequency of urination; I have had lower abdominal pains, etc., etc." I believe that there is something that can be done to reduce the incidence of such late postpartum morbidity.

### ANTENATAL CARE

One of the most important medical advances has been the development of modern antenatal care. A thorough physical examination of every pregnant woman should be made early in pregnancy, with special attention to the presence of

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foci of infection, and to the condition of the cardiovascular-renal system. The proper and early management of any positive findings here may eliminate the development of some condition subsequently which might be the origin of a long standing illness. The continued management and attention to diseases and conditions of all of the other systems of the body which are manifest during or immediately after pregnancy must be carefully evaluated and followed up so far as management of that particular condition is concerned if the patient is to be in good health.

The care of the teeth during pregnancy by the patient's dentist is, of course exceedingly important. It is most important that existing decay be adequately cared for and that foci of infection be eliminated during the pregnancy. The question of calcium metabolism in pregnancy is one which is greatly disputed and divergent opinions are held regarding the value of additional calcium medication as an aid to maintenance of calcium balance. It is my feeling that if the patient has an adequate intake of milk and vitamin D there is absolutely no indication for additional calcium medication. With vitamin D the patient is undoubtedly able to assimilate and benefit more from the calcium which she would receive in only a pint of milk than from any

\*Presented at the March 5 meeting of the Columbus Academy of Medicine, Columbus, Ohio.

calcium that I could give her in the form of tablets, wafers, capsules or whatnot.

#### OBESITY

Excess fat is something that is relatively easy to get and relatively difficult to get rid of. The usual pathologic conditions which an obese individual is prone to develop adds just that many more conditions which may contribute to the long list of possibilities that go to make up late post-pregnancy morbidity. In addition to this, an increase in weight during pregnancy may add to the size and weight of the infant which in turn may add materially to the difficulties of labor and delivery and subsequent trouble. It may also be a forerunner of a developing toxemia. One important phase; then, of antepartum care which reflects in the incidence of postpartum difficulties is weighing of the patient at each visit, and with definite instruction from you as to the amount of weight that your patient should gain. At no time should she gain over a pound a week. A sudden increase in weight should be considered sufficiently abnormal to require giving the patient some special instructions. This increase in weight may be due and most often is due to over-indulging in fats or starches. It may be due to an impending toxemia, or to hypothyroidism.

If the patient's increase in weight is due to hypothyroidism, or if the individual presents other clinical signs and symptoms of mild hypothyroidism, she should be placed on a tolerance dose of thyroid and she should be kept on this dose after delivery as well. Individuals with mild hypothyroidism are prone to have difficulty in re-establishment of their menstrual cycles following delivery, they are prone to maintain some of the weight which is gained during pregnancy and may also develop toxemia of late pregnancy. The clinical signs and symptoms of hypothyroidism are undoubtedly much more accurate for establishing a dose level than laboratory tests.

A patient with hypothyroidism may also be prone to develop gall bladder disease in association with her pregnancy or following it. There is a very definite relationship between thyroid function and cholesterol metabolism. It has been fairly well proved, however, that pregnancy itself is not a predisposing factor in the development of gall stones. It has been shown, in a recent survey,<sup>3</sup> that 79 per cent of women have borne children and that 84 per cent of women autopsied have gall stones and, further, that 79 per cent of all women with gall stones have been pregnant.<sup>4</sup> Constipation is also much more easily controlled if the metabolic rate is brought up to normal.

#### VARICOSITIES

Much postpartum morbidity of the long standing and late variety can be eliminated if vari-

cosities of the veins of the lower extremities and of the hemorrhoidal vessels are adequately cared for in early pregnancy. In the vast majority of cases there is no reason why large varicosities can not be treated by ligation or injection or that hemorrhoids can not be treated surgically in early pregnancy. The relief of these difficulties will afford much comfort to the patient both during her pregnancy and afterwards.

Many psychoneurotic tendencies in women have their origin in or are exaggerated by pregnancy. Fortunately, for many women, the nine months of pregnancy may be a happy experience. Their acceptance of their future role and responsibilities creates keen anticipation and they display a well being which at times exceeds their normal health. But, with the postpartum period, unknown and often unexpected trials appear, the feeding problem is probably the most common. The emotional stresses and strains during this readjustment period are major ones. The success with which the mother is able to accept and adjust to these problems is determined largely by her emotional maturity and stability. There are, of course, too, the actual psychoses which make their appearance during or immediately following pregnancy. The physician will fail in his duty if he does not take cognizance of the patient's psychic, as well as her physical, make-up. This should be done so that any significant personality change may be recognized and adequate treatment instituted immediately.

The early recognition and the adequate management of pyelonephritis is important not only as it may affect the outcome of the present pregnancy, but because of its far-reaching effects. This condition, if neglected, during pregnancy, has a strong tendency to become a chronic disease with recurrent acute exacerbations with the result of scarring and contraction of the kidney and later the development of hypertension. Therefore it behooves us to carefully follow patients in this regard who have had attacks of acute pyelonephritis during pregnancy.

#### TUBAL PREGNANCY

Tubal pregnancy is prone to follow mild salpingitis which may well have been the result of a low grade postpartum infection. One author<sup>1</sup> in a large series of tubal pregnancies stated that gross evidence of chronic inflammatory change in the uninvolved tube was found in 40 per cent of the patients. Sterility which follows postpartum infection may be also classed as a form of postpartum morbidity. It most certainly contributes to the mental stress with which many of these individuals suffer who are unable to have further pregnancies. Sterility may well be the result of infection either in the fallopian tube or of the cervix.

The prevention of infection of the tube is most



important in the prevention of post-pregnancy morbidity. It is my feeling that chronic salpingitis is more frequently the result of post-pregnancy state infection, either post-abortion or postpartum, than it is gonorrheal in origin. It is therefore necessary to maintain the strictest surgical aseptic technique in the handling of intra-partum patients. If vaginal examination is done at all, it, of course, should be done with strictest regard for aseptic technique. Rectal examinations should be held to a minimum because the more rectal examinations that are done the more times the vaginal mucosa is pressed by the examining finger into the cervix.

Another maneuver which contributes to puerperal morbidity is manual extraction of the retained placenta. Some feel that the only indication for manual removal of the placenta is continued, severe, postpartum bleeding which often can not be controlled until the uterus is emptied. Others add a second indication and that is prolonged retention of the placenta without serious bleeding or after the bleeding has been controlled. Whatever course you may choose, it is still to be remembered that the chief reason for the high mortality and morbidity in the cases where manual removal of the placenta is done is that in most cases, no attempt to remove it is made until the patient has lost an enormous amount of blood. This, of course, lowers the patient's resistance. The second reason is that blood transfusion and plasma transfusion are not used as freely as they should be in this particular instance. To prevent infection then, the prompt and generous use of blood transfusion is indicated in the cases that hemorrhage, and meticulous asepsis and the free use of antiseptics must be resorted to.

The use of sulphonamide powders and crystals in the uterine cavity after intra-uterine maneuvers or dusted into episiotomy and perineal wounds should not be resorted to routinely. These substances in crystalline form are definitely irritating to normal tissues. If it is felt advisable to have the benefit of the action of the sulphonamides, they should be given to the patient by mouth or parenterally.

#### BACKACHE

It has been my impression that, by and large, backache is not commonly due to intrapelvic lesions but most often to affections of the skeletal structures of the back itself, especially when pelvic inflammatory disease and endometriosis are excluded. This does not mean, however, that backache is not a common complaint following pregnancy nor does it mean that the pelvis can be ruled out especially without pelvic examination. Some cases of backache can be prevented by the proper conduct of labor, careful and accurate repair of lacerations and episiotomies and

the follow-up of women after delivery, especially with the correction of subinvolution, uterine displacement, cervical pathology, sacro-iliac strain, pyelitis, chronic constipation and the like, but backache following pregnancy due to lumbosacral and sacro-iliac strain should receive our close attention in an attempt, during pregnancy, to prevent this condition from continuing on as a persistent feature.

This point brings up the question of the use of maternity corsets. I certainly do not subscribe to the routine use of these contraptions. If the backache, during pregnancy, due to low back strain, is a persistent symptom in the last few months of pregnancy and if it can not be alleviated by a simple strapping, one must sometimes, resort to the use of a maternity corset for back support alone. Most certainly, the maternity corset, to my mind, does more harm than good if it is used purely as a support for abdominal muscles and the pregnancy. These abdominal muscles whose function is extremely important in the support of the back and in labor would certainly become weaker if they are carried in a sling throughout the pregnancy. The abdominal muscles can hold up a pregnancy as well as a corset and come through the pregnancy stronger muscles than if they are supported by artificial means. Exactly the same thing holds true in the postpartum state. Exercise, of the usual postpartum type, will strengthen these muscles whereas the use of the corset or other types of abdominal support in the postpartum period tends to weaken them. I, therefore, urge a more restricted use of corsets for antepartum and postpartum support.

#### SACRO-ILIAC STRAIN

That there is some relaxation of the pelvic joints, and especially we are interested in the sacro-iliac joints, is not denied by most authorities and that in most cases of pregnancy backaches, symptoms and signs point usually to sacro-iliac strain. The treatment of this backache, especially during pregnancy itself, depends upon the severity of the symptoms and may require the use of a strong support. This support may also have to be continued for varying lengths of time following delivery if the symptoms are still severe and until the pelvic girdle has become consolidated.

I would like to point out here that the management of this type of patient and, as a matter of fact, all patients during labor and delivery is extremely important in view of preventing chronic low back strain. Unless great care is observed, especially during anaesthesia when the patient is unable to protect herself, movement of the pelvis and thighs may cause more or less serious damage to these joints.

This is especially true when the patient is

placed in lithotomy position. Probably as much damage can be wrought when the patient is taken down from the lithotomy position as when she was being put up. Two simple things, which if done, will help prevent a great deal of this type of strain which is associated with the lithotomy position. These are: Before the patient's legs are taken down from the stirrups the patient should be pulled back so that the buttocks are several inches from the lower edge of the table; and, second, in taking the patient down from the lithotomy position, both legs should be taken down together.

Backache as a symptom of gynecologic disease is generally produced by pressure or traction on, or induration and infiltration of, the pelvic cellular tissue and the peritoneum, especially the sacro-uterine ligaments, although pressure from tumors which fill the pelvis may cause it. Pelvic disease causing backache is well defined and readily recognized. Generally it is severe, acts in a direct and easily understood manner, and always produces other symptoms. Unfortunately for the physician, women with backaches caused by such definite disease entities constitute only a small portion of those with the complaint of backache.

As I have indicated above I am also a believer in the use of postpartum exercises. Too many women are not instructed in the use of these postpartum exercises and a great many more women who are so instructed, do not do them. Either they do not feel that it is important enough (and, if that is the case, it is the fault of the attending physician because he has not stressed this point vigorously enough to the patient); or they feel that they do not have time to bother with exercises (and this is also the fault of the physician because he has not emphasized the importance of the exercises enough). Most of the poor results, you will find, from postpartum exercises are due to the fact that the patient did not take them.

#### RETROVERSION

Shute<sup>2</sup> found in cases of backache the incidence of retroversion was lower than in the normal group in a study of 94 women, who had 117 pregnancies. It was also found that pregnancy rarely altered the position of the uterus, and if it did so, it corrected the retroversion about four times more frequently than it caused this displacement. In regard to posture and backache, probably no fundamental residual change in posture can be ascribed to pregnancy itself, but the patient with poor posture or the patient who develops postural defects because of fatigue, which might be associated with her increased household duties and with the care of the newborn child, could well have her backache aggravated and accentuated due to sacro-iliac or lumbo-sacral strain. The patient will not

have a tendency to improve her posture, or to attempt to do so, unless someone tells her to.

It is interesting to note that, in the last 1,014 admissions to the gynecologic service of the Ohio State University Hospital, 296, or approximately 27 per cent of these individuals were parous women who had complaints caused by relaxation or laceration of the pelvic floor. It has been shown by some that as many as 90 per cent of primiparae show more or less relaxation of the perineal tissues after labor if episiotomy is not done and that the integrity of the perineum is maintained by episiotomy. A timely episiotomy, if properly performed and efficiently sutured, will conserve the integrity of the maternal tissue, assist involution of the entire lower birth canal, prevent disorders of micturition and defecation and reduce the risk of traumatic intracanal lesions in the child, especially if premature.

#### IRONING OUT THE PERINEUM

I have seen individuals conducting delivery who have prided themselves on the fact that they have been able to deliver a primigravida of an eight pound baby without so much as a mucus tear, and of course, without an episiotomy, the disadvantage of an episiotomy being that it greatly prolongs the physician's attendance, especially at three o'clock in the morning. Such a delivery, thus conducted, with so much agility and pride has been accomplished by so-called "ironing out" of the perineum. This procedure might better be called manual laceration of the perineum. Such a rapid disruption of the perineal tissue can not help but result in deep laceration and in much stretching of the fascia below the skin and mucosal surfaces. These over-stretched fascial structures, it is to be remembered, are the main support of the pelvic floor and they do not return to their normal state.

This procedure, then, in my opinion, is to be condemned. It is not good obstetrics—it may be good midwifery. Episiotomy, then, should be done in the instance of the large and average-sized infant, for the good of the mother and, in the case of the small and premature infant, for the good of the infant. The type of episiotomy to be performed is a matter of personal choice. The one, occasional disadvantage of the median episiotomy is the undesirable extension to a third degree laceration. Let it be stated here, however, that the repair of a third degree laceration from the extension of a mediolateral episiotomy is many, many times more difficult.

The advantages of a median episiotomy are these: The incision is made through the anatomical junction of the lateral fascial planes; it does not cut across the belly of the muscles; it does not cut across main blood vessels and nerves; there is not the tendency for upward extension of the episiotomy in the vaginal wall; the median episiotomy allows for a retraction



of the pelvic floor tissues equally on each side; it is much simpler to repair because of the anatomical separation of the tissue. Another distinct advantage is that tenderness of the scar is markedly less. I have seen many patients who have complained of dyspareunia for months following the lateral or mediolateral episiotomy. In the mediolateral incision, the sphincter of the vagina is incised and its repair often assumes the proportion of plastic surgery. Further, if the laceration extends beyond the incision, the tear may lacerate the fibers of Luschka which support the rectum so that proper closure of the laceration will be unanatomical and it is important that the rectum should not be disturbed from the fibromuscular structures which support it.

In the repair of the episiotomy the adherence to sound surgical principles is as important as is any other type of surgery. These are hemostasis and the approximation of tissue without tension. It is also a well-established fact that the finer the catgut, the less the tissue reaction. I have read one author who prefers chromic catgut as fine as is possible to obtain and he says he uses #1 or #0. Personally, I have used and I am still using #0000 or #00000 chromic catgut, single strand. Chromic catgut also causes less tissue reaction when buried than plain catgut. With the use of the fine catgut, too much tension can not possibly be brought upon the tissue because the tensile strength of the catgut strand will not permit it.

Bacteriologically speaking, it is generally conceded that the perineum is the dirtiest place in the human body, second only to the mouth and for that reason and because of contamination by the lochia and vaginal discharge, in which are found in all types of pathogenic organisms, the use of buried non-absorbable suture material is surgically unsound. It seems to me, for the same reason, subcuticular sutures have an advantage over through and through suturing of the skin of the perineum. Each needle puncture, in the perineal skin, is an additional wound which may be the portal of entrance of bacteria. Infection resulting from this may, of course, cause a disruption of the perineal wound.

In repairing lacerations and episiotomies, the usual tendency is to rely on deep bites of tissue to control bleeding. However, definite bleeding points should be ligated individually, otherwise, occasionally a serious hematoma may develop. Further, in repairing the episiotomy wound, the first suture should be placed beyond the end of the incision or wound in intact tissue because occasionally a small bleeder at this point is the source of serious bleeding and because if the upper angle of the wound is not closed, it offers an easy entry for infection and breakdown of the whole perineum.

Care should be taken that high lacerations of

the vaginal wall be not neglected. Whether they are extensions of the episiotomy or entirely separate from it, they should be looked for and repaired. Lacerations of the vagina usually heal readily but with some scar formation. If the scar formation is marked it may distort the base of the bladder, thus producing urinary incontinence. It may dislocate or fix the cervix and result in dyspareunia.

#### THE SECONDARY REPAIR

There is still a general lack of agreement as to when a tear or episiotomy that has broken down, after immediate suture, should be repaired again. It should be stated here that there is no doubt that a secondary repair must be carefully done under good operating conditions and that they may break down again within a day or so under conditions of obstetric practice in the home. A recommendation given by many authorities is that a secondary repair is best deferred for at least four months after delivery, that is a secondary repair of a perineal wound that has broken down. Against such a course, there are two objections: First, the patient is most uncomfortable at a time when she needs all her energy. Second, involution brings about a retraction of the torn muscle and the mucus surfaces and they undergo permanent shortening. With the result that undue tension is needed to re-approximate the tissue and a truly plastic operation must be done. The reason usually given for deferring the resuture of the disrupted perineal wound is that the raw surfaces are granulating and infected and union, therefore, is not likely to be obtained. However, if union is obtained and it usually is to a certain extent, much has been gained and nothing has been lost.

The seriousness of cervical tear lies not so much in the actual trauma as in subsequent events. Each lacerated cervix is a potential victim of bacterial invasion. Tears of the cervix occasionally unite by primary union but if they become infected, they do not, and they may give rise to cellulitis in the adjacent broad ligaments with resulting lifelong invalidism. Childbirth is the commonest etiologic factor and produces the largest tears. It has been estimated that about 80 per cent of all parous women have some degree of cervical laceration and about 40 per cent of these, which are unattended, lead to cervical pathology.

Injury to the cervix may be the result of too strong and expulsive efforts of the uterine muscle. As a result, ergot preparations are rarely administered before delivery—they, of course, should not be. Yet, pituitary preparations are widely used by some physicians to hasten delivery. This is a serious problem but not one to be discussed here. While we are mentioning basic obstetric principles, we would caution you to exercise extreme care in the application of

forceps and remind you that much damage can be done to the maternal organisms by the improper application of forceps or the application of forceps before the complete dilation of the cervix.

#### MANUAL DILATATION

Manual dilatation of the cervix comes in for its condemnation. Personally, I do not believe that the cervix can be dilated manually, maybe a centimeter or two—yes, but any so-called dilatation of the cervix sufficient to allow the passage of a baby's head is not manual dilatation, it is manual laceration.

Extensive lacerations, permitted to heal by granulation, increase the size of the external os and evert the lips due to scar contraction, exposing the cervical canal to direct contact with vaginal bacteria. Erosion with low grade infection, cystic degeneration, and various degrees of cervicitis are common results. And inflammations of the cervix are the commonest disturbances of the generative organs. Cervicitis is frequently complicated by cystitis. Infection may reach the bladder from the cervix by way of the lymphatics as well as by direct continuity. So, many later complaints of bladder difficulty can be eliminated by the early care of the cervix. It is also generally accepted that long standing chronic irritation bears directly upon the incident of cancer of the cervix.

The subject of periodic health examinations, which was mentioned here two weeks ago, may be well brought into the discussion of obstetrical care and the prevention of postpartum morbidity. In your advice to the patient, at her regular postpartum visits, you could well take the opportunity to urge these individuals to seek periodic health examinations. This would greatly reduce the incidence of inoperable carcinoma of the cervix and for that matter, cancer in any organ. The most important prophylactic measures include the treatment of non-malignant lesions of the cervix such as erosion, cyst, small lacerations and endocervicitis.

One point I should like to emphasize is that every piece of tissue which is removed from the cervix or endometrium be microscopically examined. This includes the apparently benign cervical polyp. It is well to remember that a small percentage of cervical polyps are malignant. This malignant change you can not see with the naked eye.

#### CERVICAL INFECTIONS

To get back to cervical infections: The environment of the cervical parametrium invites low grade infections of the base of bladder, induration and tenderness of the sacro-uterine ligaments and various degrees of congestive disturbances of the pelvic circulation. It is well known that deep cervical lacerations accompanied

by severe chronic cervicitis result in marked hypertrophy not only of the cervix but of the uterus. Sterility, spontaneous abortion, dysmenorrhea, dyspareunia, and chronic leukorrhea all have been attributed to the complicated cervical tear.

Whether the cervix should be inspected and repaired at the end of the third stage of labor, is a question. Many feel that the added risk of infection outweighs the limited advantage of immediate repair. It is generally agreed that this procedure is not free from danger. Repair and even inspection is not advisable if an infection is found to exist in the vicinity of the birth canal, or when extensive bruising of the perineum has occurred in difficult labor.

It is most certain that all principles of surgical cleanliness must be observed if the cervix is examined immediately following delivery. It is surely a procedure which must not be undertaken in the case of home delivery unless it is a question of controlling hemorrhage. Even in the hospital there must be sufficient light and assistance so that proper exposure may be obtained. Tears of 3 or 4 cm. or longer probably should be repaired and this is best accomplished with loosely tied interrupted sutures of fine catgut. One would not consider leaving a deep tear of the perineum to heal without the benefit of suture and I can see no good reason why one should expect deep tears of the cervix to heal properly without suture.

The immediate postpartum period is certainly no time to repair old lacerations. These may better be left until after the childbearing period, when they should be repaired surgically. The same may also be said of old lacerations and relaxations of the perineum. The immediate postpartum plastic repair of any of the tissues of the pelvic floor is, in my opinion, definitely contra-indicated. In the first place, the tissues are somewhat edematous and bruised. They are exceedingly vascular and control of bleeding is not satisfactory. No one would consider doing plastic surgery on a man's face if it had just been well beaten by a pair of good sturdy fists. The same principle is involved in so-called puerperal gynecology, where one attempts to do plastic repair upon tissues that have been traumatized by delivery.

Here, there is still another factor to be reckoned with. The involution of the tissue in the postpartum period with its accompanying retraction. The extent of this involution and retraction can in no way be estimated. Involution of the pelvic structures undoubtedly is not complete until a period of four to six months following delivery. Not until this period has passed, then, should plastic repair of old lacerations and relaxations be attempted. Smaller lacerations of



the cervix are best dealt with at the regular postpartum visits.

The lacerations should be handled by cauterization of the exposed cervical mucosa back as far as the functional external os. This cauterization I believe, may be better under done than over done. The procedure can easily be repeated at a latter date if necessary. The method of choice by most individuals is the linear type cauterization. This also holds true, for the most part, in the treatment of chronic cervicitis which has previously been neglected. Linear cauterization is best done with a slender nasal-tip cautery. There may be only one line, choosing the most involved area, or there may be as many as eight, all radiating outward. The patient should be urged to report back once each month or six weeks until all signs of cervicitis have been eradicated.

It is felt, by many, that gradual cauterization at intervals of one month to six weeks is a better procedure than a high amputation of the cervix. The risk, however, of producing cervical stricture with improper technique can not be too strongly emphasized. The most troublesome cases of old infection are those in which the involvement is chiefly endocervical and it is in these that good results are not obtained with cauterization.

Prenatal vaginal infection is important. Its cause should be sought out and eradicated as it may lead to postpartum cervicitis, parametritis and even perimetritis with resultant post-pregnancy involvement of the adnexa. Many patients and their physicians are of the opinion that vaginal discharge during pregnancy is physiologic. An increase in the secretions of the cervical glands is physiologic but the patient must be instructed to report any unusual vaginal discharge; and it must be explained to the patient what unusual vaginal discharge is because some patients feel that they have no unusual vaginal discharge unless they have to constantly wear a perineal pad.

#### REST BETWEEN BIRTHS

The rapid succession of pregnancies undoubtedly adds considerable to late postpartum morbidity. Contraceptive advice will and should be given to the patient who asks for it but I believe it is the physician's place, if he is not asked, to caution women against rapid succession of pregnancies. Even if it is economically sound for the patient to undertake such pregnancies, it is certainly not advisable before the period of involution is complete.

It has been stated that whatever advantage is gained by a rest period of several years between births seems to be offset, in some respects, more than counter-balanced by the aging factor, for it must never be forgotten that the most important

attribute that the childbearing woman can possess, is youth. We are not advocating several years rest between births but it does seem extremely important that at least involution be completed and that the pregnancy does add greatly to the burden of household duties. It is of interest to note that women who have had eight or more children face a much higher mortality in childbearing than those in the lower brackets. Any factor that increases maternal mortality rates can not help but increase late maternal morbidity.

Bearing in mind the old saying that a baby in the crib may be a greater load than the baby in the womb, the physician should caution his patient to be sure, that following delivery, she is physically and mentally capable of undertaking a further pregnancy. Regarding the ideal interval between births, it is undoubtedly true that immediate postpartum morbidity and maternal mortality is lowest when the interval is 12 to 24 months and much higher when it exceeds 4 years.

#### EXERCISE

The general tendency to exercise and outdoor sports has had much to do with strengthening woman's bodily structure and so indirectly with keeping her pelvic organs in their proper position. On the other hand, it must not be forgotten that the human viscera were constructed for walking on four legs not on two, and that this factor is operative behind every cause responsible for malposition of the uterus. The commonest variety of acquired retroversion occurs after delivery as the result of relaxation of the uterine support and it is extremely important to remember that this type of displacement is always the one that is associated with uterine prolapse. It is impossible for a uterus to become prolapsed unless it is retrodisplaced, therefore, retrodisplacement is the first stage or the forerunner of prolapse of the uterus.

During pregnancy there is of course an enormous hypertrophy of all the pelvic structures and of the uterine supports. Under normal conditions these structures return approximately to their former condition, although their original tone and form are never quite restored. On the other hand, a permanent laxity may develop as the result of prolonged labor, unwise instrumentation, puerperal infection, subinvolution, too early return to the upright position, pelvic laceration, and long lactation with its resultant genital atrophy. Retroversion is probably due mostly to undue stretching of the ligaments which attach to the lower uterine segment. These are of course the bases of broad ligaments and the sacro uterine ligaments. These are spread and stretched by the act of labor and usually have not retracted when the woman begins to move about. A large uterus is, therefore, not properly

supported and displacement inevitably occurs. It is, for this reason, extremely important to examine the patient at six or eight weeks following delivery so that these displacements and other pathology may be detected and corrected.

Repeated pregnancies at short intervals aggravate any injury to these ligaments and so a single pregnancy in a woman with congenital defects of the pelvic tissues may work as much harm as repeated pregnancies would achieve in a better developed woman. Late postpartum morbidity can usually be prevented by the timely replacement of a retrodisplaced uterus at the usual postpartum visit and the insertion of a pessary to hold it in place. Backache may occur and is always of the low central or sacral variety. It is probably due to the traction of the abnormally heavy uterus on the uterosacral ligaments.

#### PROLAPSE

Uterine prolapse may eventually follow unless correction of the retroversion is done promptly, because damage to the endopelvic fascia and lengthening of the uterosacral ligaments permits the cervix to slide forward in the axis of the vagina and the fundus can not fail to follow. Displacement of the tubes and ovaries is inevitable in retroversion of the uterus because their position is dependent upon the position of the body of the uterus. The circulation of the ovarian vessel is interfered with and the function of the ovary may be greatly impaired.

The normal uterine hypertrophy of pregnancy and the puerperium becomes permanent and pathologic partly as a result of the obstructed circulation and partly as a result of the overgrowth of the highly vascularized displaced tissues. Permanent fibrosis occurs in advanced cases. Marked congestion of the uterus results and will become a permanent feature unless the normal relation of the blood vessels are restored. Menstrual irregularities are common as a result of this circulatory stasis and the endometrial hypertrophy and dysfunction of the congested and displaced ovary. Vaginal discharge is common and is due to the associated hypersecretion of the congested glands of the cervix and the endometrium. The congestive type of dysmenorrhea is frequently observed and is usually in the form of an exaggeration of the more or less permanent discomfort caused by pelvic congestion. Dyspareunia may be a feature due to the increased congestion and tendency toward prolapse of the adnexa and especially prolapse, into the cul-de-sac, of the ovary.

Bladder symptoms may be caused if there is a distortion of the vesicle neck. This is especially true if there are associated injuries of the anterior vaginal wall. If retrodisplacement is discovered at the postpartum examination, the prompt use of a pessary is often curative. Habit-

ual overdistension of the bladder may be an exciting cause for failure of a pessary to bring about this cure and the patient should be cautioned regarding this possibility.

#### INCONTINENCE

The most frequent type of urinary incontinence in women is stress incontinence in which the sphincteric action of the bladder neck and urethra have been impaired by childbirth. Another cause may be the overdistention of the puerperal bladder. The same is most certainly true of the overdistention of the bladder during the first and second stage of labor. These things may be said also of the development of cystocele. Another and very frequent cause of cystocele is the overstretching of the lower uterine segment and the anterior vaginal wall in obstructed labor. When labor is active and full dilatation has been reached, if in spite of strong uterine contractions the presenting part does not descend it is obvious that that portion of the uterus and anterior vaginal wall are overstretched.

The duration of the second stage is not as important as the force and frequency of the contractions. Overstretching may result in actual rupture of the pubico-cervical fascia at its junction with uterus or in a diastasis in the midline. Damage of either type may ultimately permit the herniation of the bladder. Commoner than actual rupture of the pubico-cervical fascia is its overstretching so that the support of the bladder floor is subsequently impaired. This overstretching may also be a result of too early rising and working before involution has taken place.

Symptoms of urinary incontinence may be particularly annoying immediately following delivery. If time is allowed, however, for the patient to fully convalesce and involution to fully take place, the symptoms may disappear or greatly improve. If, however, there is indication to use a pessary for retro-displacement, in the postpartum period, complete relief of incontinence may sometimes be obtained by fitting the pessary so that just enough pressure of the anterior bar is brought against the urethra.

Prolapse of the uterus is really a hernia of the pelvic floor and is due to relaxation or relaxation with laceration of the pelvic floor and is usually associated with cystocele and often with rectocele. Prolapse may occur in young women, but is most often the feature of middle age or late life. Prolapse does not occur, except in very rare instances, in nulliparous women. As we have said, it is always in association with retroversion of which it is the second stage. It furthermore is practically always the result of obstetric injury.

The extent and the degree of the malposition depends upon the inherent qualities of the tissues



plus the type of labor and the care during this labor and delivery rather than upon the number of pregnancies. It is more commonly seen, of course, too, in poor and hard working women than in women of more comfortable circumstances. The complaints which these patients have are similar to the symptoms of retrodisplacement.

In addition to this, and many times more distressing, are the complaints relative to the cystocele. This type of postpartum morbidity, then, makes its appearance late and has to be reckoned with many years after the causative factors have come to bear. During the first stage of labor, if voluntary straining is encouraged or if it is not discouraged, the entire uterine ovoid is pushed into the pelvis and the supporting ligaments are elongated. These ligaments, which thus may be overstretched beyond physiological limits, do not cause the pelvic organs to return subsequently to their normal position. Voluntary straining during the first stage of labor, therefore, results only in permanent damage by elongating the ligamentous supports of the pelvic viscera.

#### PERINEAL RELAXATION

Perineal relaxation or failure to properly reconstruct the perineal body at the time of delivery leaves the rectal ampulla unsupported. This eventually dilates and is converted into a cul-de-sac which is further enlarged by straining, due to the difficulties in emptying the lower bowel. Further, the traction of the loaded sigmoid exerted on the posterior vaginal wall tends to eventually obliterate the posterior fornix and favor retroversion and subsequently the descensus of the uterus. One author makes this interesting observation, "Another philosophy that is prevalent is that unless an episiotomy is done the patient will have a relaxed perineum, a cystocele, or a rectocele, or all three. This philosophy has not held true in two thousand private patients examined at two months, four months and six months postpartum."

The fallacy of his reasoning is apparent. The overstretching of the fascias which support the bladder, the rectum, and the pelvic floor does not necessarily result in an immediate herniation of the viscera involved. The resultant weakness in these fascias may not make themselves apparent for many years. The damage done can be appreciated only after the hernia develops. Another investigator noted, in a series of patients who were allowed to get out of bed early, among his several conclusions that uterine prolapse was not encountered. What effect this might have twenty years hence—he did not say.

Granted, that most prolapses of the uterus occur late in life and are associated with weaknesses of the tissues that are seen in that period, it is to be remembered that the primary or un-

derlying cause is the injury which is sustained at the time of labor, delivery and the puerperium. Therefore, all that we can do to prevent overdistension and laceration of the pelvic floor will be of some avail in the prevention of prolapse in later life.

Obstetrics today is better than that practiced formerly, as shown by the only valid criterion, this is, the end result in thousands of cases. Fewer mothers die, fewer babies die, and fewer women are left scarred, either physically or mentally. However, two types of obstetrical practice have been evolved: One, which is followed by the specialist, and the other by the general practitioner. Physicians in general practice, can if they will, perform an excellent brand of normal obstetrics. When problems of major obstetrics face you, do not delay in calling consultation with an attending obstetrician. Most important of all, we should be urged to admit to ourselves, if not to the patient, the shortcomings of our obstetrical care. And, if we will practice obstetrics to the very best of our knowledge and ability, I am fully aware of the fact that late postpartum morbidity can not be entirely overcome, but I am sure that it will be greatly lessened.

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#### Excessive Use of Sick Leave

A comparative study of important socioeconomic and medical factors in the lives of 100 female office workers who had records of excessive sick leave during a six-month period, and of 100 female office workers who took no sick leave during the same period of time revealed interesting differences between the two groups. The group which took excessive sick leave was made up of a greater number of more recently employed women whose salaries were lower and whose government positions carried little or no responsibility. There were comparatively few employees in this group who had received excellent efficiency ratings. In general, they were young, married, and assumed a considerable amount of domestic responsibility in addition to their job. The records showed that both sick leave and annual leave were used to excess by this group. . . . Thirty to 40% of sick leave absences were suspected to be taken for personal reasons or very mild illnesses since the number of sick leave absences dropped that percentage on paydays.—Leon Schwartz, Surgeon (R)USPHS, Washington, D. C.; *Industrial Medicine*, Vol. 14, No. 8, Aug., 1945.

# Human Ornithosis: Report of a Case With Relapse

HERMAN A. FRECKMAN, M.D.

THE importance of primary atypical pneumonia as an entity has been definitely established. However, the possibility of ornithosis as a frequent cause of sporadic atypical pneumonia is not commonly recognized. There is the growing conviction, nevertheless, that human ornithosis is much more prevalent than it is diagnosed. There are at least three reasons for this:

First, the prevalence of ornithosis in pigeons. Meyer and his co-workers<sup>1</sup> after having made a survey, in various areas throughout the country, concluded that a very high percentage of the examined pigeon flocks gave significant psittacosis complement fixation reactions. In fact, Meyer has stated that approximately 40-50 per cent of the pigeons, universally, are infected with ornithosis.

Secondly, human ornithosis is a rather newly recognized disease and, until recently,<sup>2,3</sup> has not been given sufficient publicity to the medical profession, in general, so that the diagnosis would be considered as a possible etiological factor in "virus" or primary atypical pneumonia.

Thirdly, the availability of laboratory facilities in the United States for making the confirmatory psittacosis complement fixation test is limited, as far as I can determine, to the laboratory of Dr. K. F. Meyer\* at the University of California. This fact, also, makes it difficult to arrive at a diagnosis.

In 1941, Meyer<sup>4</sup> first reported the isolation of psittacosis-like virus from the lung of a patient who had been exposed to a flock of racing pigeons. Sixty-three per cent (19) had a positive psittacosis complement fixation reaction. Four pigeons in this flock of 33, were infected with a virus indistinguishable from that of the virus isolated from the patient. In 1942 the term ornithosis was suggested by Meyer and his co-workers<sup>1</sup> as a disease in the human being following exposure to infected pigeons, doves, chickens and similar fowl. They also suggested that the term psittacosis be applied only to the infection occurring in man after exposure to parrots, parakeets, lovebirds, canaries, and other psittacine birds.

Since the work of Meyer, an increasing number of cases of human ornithosis have been reported. Heilman and Herrell,<sup>5</sup> and, more recently, Levinson, et al.,<sup>2</sup> have summarized the literature.

\*It was only through the courtesy of Dr. K. F. Meyer of the George Williams Hooper Foundation at the University of California, that it was possible for the psittacosis complement fixation test (given in this case report) to be performed.

Submitted June 7, 1945.

## *The Author:*

● Dr. Freckman, Cincinnati, Ohio, is a graduate of the University of Cincinnati College of Medicine, 1937.

Levinson's paper contains an excellent summary of the clinical features of ornithosis which includes the method of transmission, incubation period, symptomatology, physical, laboratory and X-ray findings, course of the disease, diagnosis and treatment.

In regard to therapy, Turgasen<sup>3</sup> recently reported a case in which penicillin was used with beneficial results. Heilman and Herrell,<sup>5</sup> in experimentally produced ornithosis in mice, found penicillin to be definitely curative. This work prompted Turgasen to use penicillin in his case. Parker and Diefendorf<sup>6</sup> found penicillin to be definitely effective in chick embryos infected with the psittacosis virus. Very recently Flippin, et al.,<sup>7</sup> reported a case of human psittacosis in which penicillin apparently was of definite value.

## CASE REPORT WITH RELAPSE

**History** (including epidemiology): J.S., a white man, aged 54, has been a pigeon fancier and breeder of racing pigeons for many years. He daily, until the onset of his illness, cared for his flock which he kept in a garage in the rear of his home. Since August, 1944, he had been losing an occasional pigeon which died after suffering from a cough and what he termed, the "snuffles". During the course of his illness, five of the patient's pigeons died with these symptoms. When cleaning the loft, the patient stated that the pigeons often stirred up considerable dust flying about the garage.

This man was in good health until Nov. 22, 1944, when he first experienced an onset of chilliness, malaise, aching pains in the back and extremities, and moderate frontal headache. He said that he had but little coughing at this time. He thought that he had the "flu" and stayed in bed until Nov. 27. On Dec. 1, his symptoms returned with increased severity and with the addition of a moderate hacking, unproductive cough.

The patient had no medical attention until Dec. 4, when I was first called to see him. At this time he complained of moderate frontal headache and pain in the cheeks, moderate photophobia, malaise, extreme weakness, a slight unproductive, hacking cough, marked anorexia and occasional abdominal distension but no diarrhea. He stated that at intervals he blew blood-tinged mucous from his nose. His wife stated that the patient had been "mentally cloudy" for the previous few days and that since Dec. 1, he had a daily temperature varying between 101-103 de



grees F. The patient refused hospitalization and, as a result, was treated at home.

**Physical and Laboratory Findings:** Only the significant findings will be described; irrelevant material will be omitted. When first seen on Dec. 4, the patient not only looked ill, but he also was somewhat mentally incoordinated and irritable. The temperature was 103 F., the pulse 68, and the blood pressure 140/80. His eyes were sunken and bright, the cheeks flushed, and moderate photophobia was present. The body showed signs of a recent marked weight loss. The skin was hot and dry; the tongue was furred; the breath was foul; the abdomen was noticeably distended. Examination of the chest revealed at the right base, posteriorly, slight dullness with diminished breath sounds and occasional, fine crepitant rales.

Urine examinations on Dec. 5 and Dec. 8 were negative. Examination of the blood on Dec. 6, revealed a red count of 4.12 million, a white count of 7,200 and a hemoglobin of 13.5 gms. The differential count was neutrophils 78 per cent, lymphocytes 18 per cent, monocytes 3 per cent, and eosinophiles 1 per cent.

A telegraphic report by Dr. K. F. Meyer on the patient's serum taken Dec. 30, (38 days after the onset of his illness) stated "positive psittacosis in serum. Dilution 1:256."

X-ray examination of the chest by Dr. N. Flax on Jan. 3, 1945, (taken when patient was ambulant) showed a "practically complete resolution of a right lower lobe pneumonia".

**Clinical Course and Treatment:** On Dec. 4, the patient was given full therapeutic doses of sulfadiazine which was discontinued on Dec. 12. The temperature varied between 102-103 F. until Dec. 7, when it fell to 100 F. and on the following day to normal. The pulse stayed remarkably steady at 68. The patient felt better and continued to run a normal temperature and to eat and gain strength until Dec. 17. On this date he suddenly experienced a severe shaking and teeth-chattering chill. His temperature rose to 104 F., but the pulse was only 88 and the respirations 24. The patient looked ill but he stated that he did not "feel bad". He complained of soreness in the right upper chest anteriorly; there was no pain or discomfort on inspiration. The only significant finding on physical examination was a questionable slight dullness and diminution of breath sounds over the upper-third of the right chest, anteriorly. No rales nor friction rub was heard. He stated that he had no actual cough but occasionally had to clear his throat. He was again given sulfadiazine; however, it apparently had no effect on his temperature.

On Dec. 21, he was emphatically told that unless his temperature (it was 103 F.) became normal on the following day, he would be hospitalized. Neither he nor his wife desired hospitalization, and, as a result, his wife (without my knowledge) gave the patient what she described as a "sweat treatment" using heat to the body and the giving of hot drinks. Strange as it may seem, the morning following this "heat treatment" (Dec. 22) the patient's temperature was normal and he made an uneventful recovery, remaining fever-free. Sulfadiazine was continued until Dec. 26.

#### CONCLUSIONS

1. This case is reported to help confirm the growing conviction that human ornithosis is

probably a more frequent cause of sporadic atypical pneumonia than is generally believed and to call attention to the fact that ornithosis can occur in this area and may be more prevalent than it is recognized. The difficulty is the lack of laboratory facilities for conveniently determining the psittacosis complement fixation test.

2. A case of moderately severe ornithosis with relapse has been described. The diagnosis was confirmed by the psittacosis complement fixation test performed on the patient's serum by Dr. Meyer in his laboratory. During the course of the disease, it is not uncommon for the temperature to return to normal for a few days and then suddenly show a relapse. As far as I can ascertain, it is unusual for a period of 10 days to occur during which clinically the patient shows recovery and then suddenly develops a recurrence of the disease with marked intensity.

3. In regard to the treatment of ornithosis, it is generally agreed that the sulfonamides have little, if any, effect upon lowering the temperature or favorably influencing the course of the disease. In this reported case during the first sulfadiazine course, the disease apparently was brought under control. However, this was not substantiated by subsequent treatment with sulfadiazine when the patient had his relapse.

The application of external heat and the giving of hot drinks to the patient by his wife caused him to have drenching sweats and a fall of temperature to normal within 18 hours with uneventful recovery. Whether or not heat is effective in the treatment of this disease is problematical. In the reported cases of ornithosis the temperature usually fell to normal in from one to five weeks, regardless of the therapy used.

The work of Heilman and Herrell and the cases reported by Turgasen, Flippin, et al., (which were mentioned in the introduction) suggest that penicillin may be of definite value in the treatment of this disease.

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# Uro-Genital Tuberculosis

VICTOR C. LAUGHLIN, M.D.

**T**UBERCULOSIS is a disease common to early adult life. Following pulmonary tuberculosis renal tuberculosis is next in infrequency. During the past 40 years public health statistics show that the incidence of tuberculosis among the general population has been decreased at least 50 per cent. Physicians today are better equipped to recognize the earlier manifestations of pulmonary tuberculosis. Earlier diagnosis of pulmonary tuberculosis leads to better treatment and quicker cures which in turn means less renal or urinary tuberculosis. Recognized cases cease to be a source of danger to others.

## TUBERCULOSIS OF THE KIDNEY

Tuberculosis of the kidney is generally secondary to some original focus in the lungs or in the bones. There are three avenues by which the tubercle bacillus can enter the body:

(a) Sucked into the lungs with the air we breathe.

(b) Ingested with the food we eat or drink.

(c) Entering through the protective covering of the body, the skin.

The classic manner in which to discuss tuberculosis of the urinary tract is on an anatomical basis.

We now believe that the term renal tuberculosis should read, urinary tract tuberculosis, or uro-genital tract tuberculosis. Clinicians have repeatedly observed that tuberculosis at one point in the genito-urinary tract may spread to any other part of the tract.

## SYMPTOMS OF URINARY TUBERCULOSIS

**Frequency of Urination.** In young adults among whom tuberculosis of the kidney is most frequent this symptom is the outstanding one. The frequency of urination is insidious in its onset so that the patient can not tell the exact date on which the first symptoms occurred. Sometimes the frequency has endured from 3-5 months. Generally the frequency is of a 15-20 minute type, day and night. It is accompanied very often by strangury and tenesmus. The patient's suffering is intense. This frequency has one distinguishing feature from ordinary frequencies and that is it persists at night as well as in the day.

**Pain.** Painful urination may be so closely associated with the frequency as to not stand out as a distinct symptom. Pain may be present as

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a constant soreness over the bladder area. A certain number of renal tuberculosis have pain in and over the kidney. Sometimes, in an elderly patient, the pain in the kidney becomes the outstanding symptom.

**Hematuria.** Blood in the urine is commonly rated as the one outstanding symptom of tuberculosis of the kidney, but not over 15 per cent of the renal tuberculosis cases have gross blood in the urine.

**Other Urinary Symptoms.** Sometimes a patient will have a rather complete incontinence of urine so that there is continuous loss of urine or dribbling. Occasionally in male patients there may be a persistent urethral discharge to be differentiated from a venereal disease.

**Systemic Symptoms.** The renal tuberculosis patient is almost always ambulatory. Generally they look well, often they are fat. They seldom run a fever and those that do have an elevation of temperature, usually have an active pulmonary tuberculosis as a primary focus. Night sweats, weakness, digestive disturbances or nervous manifestations are not at all common.

## DIAGNOSIS

The diagnosis of renal tuberculosis by a competent urologist is ordinarily extremely simple but often it may be difficult and complicated. The first consideration is whether tuberculosis exists elsewhere in the body. X-rays of chest should be made and studied.

Sputum should be searched for bacilli. The urine should be collected for 24 hours at a time, all of it saved and all of it sent to the laboratory to be searched for acid fast bacilli. The laboratory will need the whole quantity.

The tubercle bacilli having been found, the urologist will next want to know its origin in the urinary tract and to this end a careful cystoscopic examination must be done. Ureteral catheters are passed to the kidney and the urine collected in separate bottles or test tubes and



again searched for tubercle bacilli. Usually one side or the other will yield acid fast bacilli. A pyelogram outlining the renal pelvis will confirm the diagnosis by delineating the filling defects.

Symptoms and findings pointing to tuberculosis of the kidney are then:

(a) Acid fast bacilli recovered in the gross urine.

(b) Acid fast bacilli recovered in the urine from one particular kidney.

(c) The X-ray findings, minute or gross changes in the pyelograms.

When the clinician adds these to the symptoms pointing to tuberculosis of the kidney then the diagnosis of tuberculosis of the kidney can be made.

#### TREATMENT

1. The urologist must decide whether the case diagnosed as renal tuberculosis is medical or surgical. The greater number are surgical. Some are bilateral or advanced so that no surgery is indicated.

2. Some of the very early ones may heal spontaneously but this is still a debatable question. Tuberculosis of the kidney is bound up with the whole general problem of tuberculosis.

3. It is very probable that tuberculosis is never primary in the kidney but is spread through the kidney by the blood stream. It not infrequently happens that, by the time the patient develops a renal tuberculosis, the original focus of infection, which might have been in the lungs or bones, has healed and there remains small or no evidence of its former existence. Tuberculosis in the kidney in such case may be thought to be primary.

**Tuberculosis of the Ureter:** This condition is secondary to renal tuberculosis usually, rarely the result of an ascending infection or lymphogenous dissemination. The infectious tuberculous ulcerations within the ureter, are frequently the source of deformities which may obstruct or block the urinary stream, greatly change the size, shape and structure of the ureter and give rise to typical urographic findings. The ureterograms or pyelo-ureterograms are valuable diagnostic procedures in lesions of the ureter.

**Tuberculosis of the Bladder:** Tuberculosis is usually carried to the bladder by way of the urinary stream. A cystoscopic examination will show the bladder to be in varying stages of inflammation or inflammatory ulcerations. Often tubercles or "vegetations" may be on the mucosa surrounding the ureteral orifice of the offending side. The bladder is customarily irritable and contracted with limited capacity which accounts for the characteristic symptom of frequency. The symptoms already set forth under renal tuberculosis are shared by tuberculous lesions of the bladder viz., frequency, tenesmus, dysuria and painful hematuria.

**Tuberculosis of the Urethra:** This condition is

almost invariably a descending infection. It may simulate gonorrhea and must be differentiated from venereal disease generally. Serious deformities and stricturing of the urethra may result. The effect of these obstructive changes upon the upper urinary tract can be serious.

**Tuberculosis of the Genital Tract:** In the genital tract tuberculosis is usually primary in the epididymis but even then it is secondary to tuberculosis elsewhere in the body. In this region it has a strong tendency to chronicity and spread. Gradually the entire epididymis, the vas deferens, the seminal vesicles, the ejaculatory mechanism and the ducts of the prostate become infected. Genital tuberculosis stubbornly resists treatment, surgical as well as medical.

#### SUMMARY

A basic, elementary presentation of the subject of uro-genital tuberculosis, offering no innovations. A simple reminder that tuberculosis is an important entity in uro-genital infections must receive consideration and may be confused with venereal disease.

#### CORRECT USAGE

The definitions given are in accordance with the usage of the A.M.A. Credit should be given to Fishbein, M.: Medical Writing. The Technique and the Art, Chicago, A.M.A., 1938, pp. 64, 74 (by permission of the publisher):

|                         |                                                                                                         |
|-------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Tubercular</b>       | nodular.                                                                                                |
| <b>Tuberculous</b>      | pertaining to tuberculosis.                                                                             |
| <b>Dilatation</b>       | state of being dilated.                                                                                 |
| <b>Dilation</b>         | act of dilating.                                                                                        |
| <b>Physiocochemical</b> | pertaining to physical chemistry (or to physics and chemistry).                                         |
| <b>Physiochemical</b>   | pertaining to physiologic chemistry.                                                                    |
| <b>Dextrose</b>         | U.S.P. for d-glucose (the hexose administered intravenously and erroneously called "glucose").          |
| <b>Glucose</b>          | U.S.P. for the syrupy liquid made by incomplete hydrolysis of starch; called "corn syrup" by the laity. |
| <b>Optic</b>            | pertaining to the eye.                                                                                  |
| <b>Optical</b>          | pertaining to light or the science of optics.                                                           |
| <b>Classic</b>          | typical                                                                                                 |
| <b>Classical</b>        | pertaining to classical civilization and languages.                                                     |
| <b>Infection</b>        | invasion by bacteria, protozoa and helminths.                                                           |
| <b>Infestation</b>      | invasion by arthropods, including ticks, mites and insects (American Society of Parasitologists).       |

—R. G. LEHMAN, M.D..

# Cancer of Rectum and Pelvic Colon

WALTER H. HAMILTON, M.D.

CANCER of the lower bowel and rectum is the second most common of all internal malignancy. It is perhaps the most hopeful by revealing the highest percentage of arrested cases for three to five years. The number of cases with satisfactory prognosis is increasing constantly, regardless of the usual delay in diagnosis and beginning of treatment, of five to fourteen months from the time the symptoms are first noticed. In a great many of these cases definite diagnosis is delayed six to eight months during which time the patient is improperly treated and valuable time is lost. Cancer in this portion of the intestinal tract is being recognized more frequently, as time goes on, due to more thorough training of the undergraduate student and improved diagnostic technique.

Seventy-five per cent of all large bowel malignancy occurs in the pelvic colon and rectum. It is most frequently found between the ages of 40 and 65, but may occur in any age, and in the ratio of 2-1 male to female sex. Over three-fourths of all tumors found in this area are histologically adeno-carcinoma.

## THE SYMPTOMS

The symptoms of cancer in the recto-sigmoid are vague and vary widely.

Specifically, the onset of symptoms is usually insidious and there are few characteristic early complaints. Constipation is assumed to be a normal characteristic by most patients in middle life, and they usually pass it off as insignificant. They relieve themselves with various enemata or gradually increased doses of laxative. But, constipation alternating with diarrhea is also one of the indications of the malignant lesion in its early stages. Remember though, the patient will give such moderate symptoms very little consideration.

Rectal bleeding, consistent and dark red in color, any change in the bowel habit such as diarrhea or alternating constipation and diarrhea urgent and frequent desire to stool, intestinal flatulence and feeling of incomplete evacuation is significant. An intolerable ache or "bearing down" sensation, sense of pulling in lower pelvis or backache is a frequent complaint. These complaints should make us suspicious of a malignancy of the lower bowel or rectum. These patients should be thoroughly investigated until the tumor can be found or until all the symptoms can be perfectly justified on a benign basis.

Some or all of these symptoms may be found

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in such non-malignant cases as strep-ulcerative colitis, amebic dysentery or in widely infected multiple necrosed rectal fistulae or benign papillomas.

The similarity of symptoms of these widely differentiated conditions is a challenge to the examining physician and he should never discontinue his examination until a definite diagnosis has been established.

## THE DIAGNOSIS

The diagnosis can be made in 65 per cent of rectal or sigmoid cancer by palpating the rough, indurated cauliflower-like lesion during careful digital examination. Growths just above the level of the examining finger, up to a distance of 21 cm. or up to the mid-section of the sigmoid can be visualized through the sigmoidoscope. However, the examiner may at times neglect even a digital examination during the busy office hours and overlook, in this way, a definite easily palpable tumor.

Therefore, we must educate the patient to present himself early if any of the above symptoms appear and urge the attending physician to thoroughly examine and diagnose every case if we hope to increase the number of operable cases and in this way better our end results.

We believe the reason we overlook these serious cases is that too many doctors consider all rectal diseases as simple and tend to minimize them and their symptoms. This gives the patient a false sense of security and he may shop from one doctor to another with often no attempt made to examine the rectum. We have seen many of these cases that have become inoperable by this delay in treatment. Again many cases report one or more "rectal operations" for hemorrhoids or ulcer in an effort to control rectal bleeding, that was later discovered to be from a tumor higher up.

Ninety per cent of these tumors could have been visualized by a sigmoidoscope or palpated on digital examination. Since pain is rarely an outstanding complaint the average patient is willing



to wait for spontaneous improvement and then only seek more extensive investigation and relief when general debility and anemia indicate a late stage in the condition of the disease.

Cancer of the rectum and pelvic colon is a curable disease in an early stage where the growth has not extended to surrounding organs and can be removed. However, we have seen many cases where there was evidence of malignant process for 20 to 24 months and recurrence has not followed resection of the tumor and glands.

The only saving factor in many of these patients is the slow metastasis of the tumors of the lower bowel. For this reason prognosis of pelvic cancer is better following resection than that of malignancies in any other organ.

A frequent mistake is made by depending upon the X-ray for final diagnosis of cancer of the pelvic colon. Cancer in this section of the colon is usually not visualized with the X-ray unless the growth is completely surrounding the bowel. This is rare. However, it is satisfactory for other portions of the bowel and X-ray will show the presence or absence of metastasis of the boney pelvis. A thorough digital and proctoscopic examination will reveal 80-90 per cent of these tumors and avoids embarrassment later.

The only satisfactory treatment of cancer of the rectum and pelvic colon is radical resection of the growth and glands in the surrounding tissues. The resection must be well on each side of the tumor and include a wide excision of the gland bearing areas. It is wrong to assume that a malignant process of small size can be removed by conservative operation and a large tumor should be removed widely. The small carcinoma may be much more active than a large obstructing one and in order to include all involved tissue must be removed radically.

The mortality of resection of bowel tumors is now below 10 per cent. The operability is becoming higher as methods of diagnosis improve and the recurrence is being reduced.

Each patient must be considered individually and the operation fitted to the type of tumor present, in place of adapting the disease process to a certain surgical procedure.

#### THE FOUR TYPES OF OPERATION

There are four types of operation that we commonly use. First: The combined abdomino-peritoneal resection—Miles one stage. This has many modifications but Miles was the first to describe it and it should bear his name. This is the best operation for tumors low in the bowel and rectum and gives the most satisfactory results.

Second: Resection and primary anastomosis with supplementary caecostomy.

Third: Two stage resection in very poor risk cases—used mostly in low rectal tumors if patient can not stand one stage.

Fourth: Extra peritoneal resection—gives very good results in tumors above the pelvic brim that can be mobilized.

Careful preoperative procedure and preparation is very important and account a great deal for the lowering of the mortality rate in these extensive operations. Most of these patients are anemic, debilitated, partially obstructed and markedly dehydrated and must be returned to as near normal as possible during the preoperative period. This usually takes six to eight days.

I. V. fluids, 5-10 per cent glucose (saline) 2-4000 cc. daily to hydrate body cells and build up glycogen liver content.

The diet should be low-residue, feedings composed of carbohydrates 16-1800 calories, proteins 4-600 calories, fat 50 gms-400 calories, amino acids 400 cc. 20 per cent and supplementary vitamins. Approximately 25 per cent of these patients show a hypoproteinemia.

Sulfa therapy daily for four days before operation. Careful cystometric readings.

Three days preoperatively we start 60 grns. glucose or lactose every four hours for 16 doses. Daily irrigations of rectum with boric solution followed by aspiration reduces toxic absorption. The bowel is decompressed with  $MgSO_4$  or sodium phosphate. The solution we generally use is ounces one of  $MgSO_4$  in ounces eight of water. One ounce of this solution is given every two hours during the days of preoperatively period or until bowel is clean, or for some reason is contraindicated.

The evening before operation a mild sedative is given and the Foley indwelling catheter is placed in the bladder and stomach suction tube is started.

The morning of operation a 10 mgm. dose of vitamins is ordered per I. V. Also the usual preoperative medication.

Postoperative treatment of these cases is also highly important. Fluids 2500-4000 I. V. glucose and saline or distilled water daily unless contraindicated by a marked hypertension and arteriosclerosis. This also should be determined by frequent B. P. readings and laboratory findings. Oxygen is administered in high concentration for 24 hours. This greatly reduces shock symptoms. Whole blood transfusions as needed to combat anemia and blood loss. In the average case 500 cc. whole blood during the operation and 250 cc. a day for 2-3 days, or as indicated thereafter. The urine should be kept alkalized and the PH factor above 7.

Anesthesia procedures: Spinal anesthesia is used routinely and is usually supplemented with sodium pentothal and oxygen. This type of anesthesia has given us the most satisfactory and prolonged relaxation. It appears to be more favorably tolerated than any other type.

Pronouncement of the diagnosis: An important feature in the management of these cases is the handling of the patient and the family at the initial examination. As we well know the psychology, like the disease process, of each patient is an individual problem and must be considered while discussing the management and details of the case. The unfortunate stigma that attends the word cancer and the false conception of its incurability have been heard by all and often the family and possibly the patient accept this diagnosis as a death warrant. The ability to receive bad news without hysteria is denied a great majority of persons. However, since intelligent and emotional stability are so variable in different individuals there is no set rule for discussion of your final diagnosis.

#### THE ART OF MEDICINE

Many surgeons and therapists advocate an immediate blunt and direct declaration of the diagnosis and allow the family and patient to adjust themselves as well as possible to the coming ordeal. The patient, as a rule, knows that his symptoms signify some serious condition and he expects a clear-cut discussion even though he may have been minimizing his feelings and reactions to the family and his physician.

The suspicion of cancer is probably in the mind of the majority of our patients. However, few will have the courage to ask, "Do you think it is cancer?"

The family physician who knows the background and character of these patients rarely treats them. Therefore it is up to the surgeon or radiologist to pronounce the diagnosis and answer all questions of the patient and plan the method of treatment after completing the examination.

The surgeon must rapidly appraise the apparent psychological reaction of the patient and discuss the diagnosis and management in a way to fit the patient's reaction.

After the initial examination and discussion and noting the patient's reaction the surgeon usually can decide whether to announce the diagnosis immediately, withhold that information until a later time, or wait for further questioning from the patient. The family always should be informed of the exact nature of the disease at the earliest moment so that they can see that the patient cooperates diligently and also that there is no misunderstanding of the seriousness of the condition.

Considerable stress should be made of the encouraging results seen in similar cases of this type of tumor. This will minimize his apprehension and tend to help his morale for the management of the case while hospitalized. Explain that the tumor or growth will respond to proper treatment if started immediately, but that it is

subject to cell change and extension if allowed to progress. The word cancer should be avoided as the average patient suspects that the tumor is malignant or pre-cancerous, and will appreciate a considerate discussion rather than the alarmist attitude that no help is possible.

The family is often harder to handle than the patient. We have seen many cases where the wife will say "Don't ever tell him what the trouble is. He will have a nervous breakdown." In two such cases recently the patient, during the examination, asked the question, "Doctor, do you think it is cancer?" When told that there was a good probability of malignancy he said "I have thought so for the last seven weeks and told one of my previous examining physicians that I thought it was cancer". These patients took the news bravely and without emotion but the family of both were emotionally unstable and had to be warned not to show their feelings to the patient.

#### THE VALUE OF THE TRUTH

I do not believe in telling any patient an untrue statement about his condition whenever he asks the question. However, the manner of giving him the diagnosis should be considerate and gentle, with emphasis on the encouraging aspect of the condition rather than cruel and alarming. However, no case of tumor of the pelvic colon or rectum should be minimized with a friendly "everything will be all right" attitude. Any resection of the bowel or rectum, with or without colostomy is a major procedure and comparing it to an appendix or gallbladder shows bad judgment and leads to loss of confidence of the patient.

In a recent series of 39 cases of cancer of the lower colon, at the University Hospital, in all ages and various stages of development 13 or 33-1/3 per cent were found to be extended to adjacent organs and complicated with liver metastasis. With few exceptions these inoperable tumors were found in those patients giving a history of rectal bleeding and change of bowel habits exceeding twelve months. In the remaining 66-2/3 per cent or those cases in which there were no gross extension or liver metastasis there were two deaths or a mortality of 8 per cent. The survivors all reported such a marked relief of symptoms that the inconvenience of a colostomy was only mentioned by two patients.

On the basis of these figures and a comprehensive study of the histories we may assume that our only possibility for an improvement in our operability and satisfactory cure is: First, an early correct diagnosis; and, second, a wide radical resection.



# Combined Anesthesia

JOSEPH P. FAKEHANY, M.D.

THE ideal sought for by every anesthetist is to produce anesthesia which is conducive to little shock and also makes for greater ease in the surgeon's operative efforts. One also wishes to leave the patient's memory of the anesthetic a pleasant one, and not wrought with disagreeable impressions. Attempt is also made to minimize the postoperative complications which may be derived from the anesthetic.

Today, our armamentarium of anesthetics is many, but each in one respect or the other, may fall short of our goal. However, in the combination of several we may attain our purpose. The combination of two or more anesthetics to obtain insensibility to pain is described as combined anesthesia or, as Dr. John S. Lundy labeled it in 1926, "balanced anesthesia".

In combined anesthesia, the burden of the anesthetic is carried by several anesthetics instead of one, the load being divided among the two or more we may use. Two or more anesthetics in small amounts is less shocking than one in massive doses. Some anesthesiologists have for years advocated the use of combined anesthesia because of the less shock it entails and the more perfect anesthesia obtainable.

An integral part of any anesthetic and especially in combined anesthesia is adequate preoperative medication. This further lessens the burden of our anesthetic agents and the amount necessary to gain our desired results.

With the advent of curare, the more general use of pentothal sodium, and the attraction regional anesthesia is at present holding for many anesthesists, we have here the basis of many combinations with our subarachnoid and inhalation anesthetics.

Instead of using a large dose of agent in spinal anesthesia, a much smaller quantity may be given supplemented by analgesic doses of cyclopropane, nitrous oxide, or pentothal sodium intravenously.

Pentothal sodium is one of the most flexible anesthetics in this respect. It combines very well with many other anesthetics. It can be used merely as an induction or may be given in the patient's room prior to the use of another anesthetic in the operating room if the individual is apprehensive. It may also be used rectally in this respect to great advantage. It diminishes the amount of subsequent anesthesia necessary, whether it be cyclopropane, nitrous oxide, or ether. It may be used to supplement a waning spinal anesthetic. In combination with regional

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anesthesia, especially surgical caudal or fractional spinal, very small amounts are necessary to produce unconsciousness.

Pentothal sodium with nitrous oxide offers a good balanced anesthesia. Greater quantities of oxygen may be used with nitrous oxide and fair relaxation obtains. Pentothal sodium combines well with cyclopropane. The frequency of cardiac arrhythmias usually seen with heavy cyclopropane anesthesia and the depressing effect with too prolonged and deep pentothal anesthesia are lessened because smaller quantities of each are used.

Curare, one of our most recent adjuncts to anesthesia, is rapidly proving its worth in this specialty as it has in shock therapy. The essential feature of curare relative to its use in anesthesia is its ability to produce muscular relaxation by interrupting the nerve impulses to striated muscle. It combines most effectively with cyclopropane. Two of the untoward features associated with cyclopropane anesthesia are laryngospasms and cardiac arrhythmias. Although these disturbances are usually combated effectively by the skilled anesthetist, still they are cause for some concern. Curare diminishes their occurrence by causing relaxation of the laryngeal muscles and decreasing the amount of cyclopropane needed. Arrhythmias usually occur in profound cyclopropane anesthesia.

The use of curare with ether is not as satisfactory. Work is being done at present on the use of curare with nitrous oxide. If results are favorable whereby we may obtain the relaxation that curare offers along with the use of larger percentages of oxygen with nitrous oxide, then we may have an ideal type of anesthesia.

Ease in the production of anoxic states and inadequate relaxation are characteristics of nitrous oxide anesthesia, yet it has the advantages of being non-inflammable, non-explosive, and has a very pleasant induction.

Curare combines effectively with pentothal. At

times it may diminish as much as 50 per cent the amount necessary in abdominal operations, thereby minimizing the degree of depression yet simultaneously obtaining good muscular relaxation.

Curare can be used to supplement a spinal anesthetic which has worn off, especially at the time of closure of the abdomen. An analgesic dose of cyclopropane is begun prior to the administration of the curare. Relaxation almost as complete as spinal ensues.

Other excellent combinations are cyclopropane-ether, nitrous oxide-ether, cyclopropane-spinal, and nitrous oxide-spinal. Combinations of three and even four anesthetics may be used if necessary.

Use of a combination of anesthetics may be termed "spot" anesthesia. In other words, using an anesthetic at the time when it can be utilized to greatest advantage. As examples we have the use of curare for closing the peritoneum when a spinal has lost its effect or the use of pentothal sodium intravenously or rectally as an induction for a highly nervous person, or the use of nitrous oxide for a conization of the cervix in which an electrical unit is used followed by cyclopropane, which is explosive, for work in the abdomen.

An example of balanced anesthesia may be had from the following case of an 165-lb woman on whom a cholecystectomy was done. She was given three grains of nembutal and an HMC No. 1, preoperatively. A spinal of 120 mg. of metycaine\* was deposited between the 2nd and 3rd lumbar vertebrae. An analgesia of cyclopropane was begun just prior to the incision. In 70 minutes, at the time of closure of the abdomen, 40 units of curare was injected intravenously as the effects of the spinal had worn off. Closure was completed satisfactorily. At no time during the operation were great doses of any one anesthetic used. The patient reacted quickly with a minimum of anesthetic trauma.

In concluding, it must be warned that one must be careful not to administer inadvertently too great doses of combined anesthetics, as it readily can be foreseen what deleterious results may follow.

\*Eli Lilly.

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## KEEPING UP WITH MEDICINE

THE problem of the graying of hair is a most complex one. Malnutrition certainly is one cause. I, personally, think it a safe rule to look upon gray hair as a sign of disease and degenerative changes until it can be proven otherwise beyond any shadow of doubt.

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D R. CLARENCE MILLS of Cincinnati has shown that there exists a highly significant relationship between atmospheric pollution and respiratory disease death rates in the various districts of Cincinnati and Pittsburgh.

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THE most frequent toxic effects of benzedrine have been restlessness, insomnia, talkativeness, irritability, confusion, hallucinations, and delusions. There have been a couple of fatalities from the drug. We should remember the drug may produce addiction.

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THE opportunity to organize the demand for state-controlled compulsory sickness insurance is more important than the need for medical care.

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SOME are worrying about the use of the male hormone in the ageing since it is known to be carcinogenic in large doses.

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THE American Heart Association condemns the use of sulfa drugs in the treatment of rheumatic fever.

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WE ought to caution our patients about the use of DDT. In addition to poisoning themselves and their domestic animals, they may kill all of the butterflies, bees, and other insects which carry pollen from one plant to another, fertilizing them. Gone will be the honey from the hive and all the birds to eat the dead insects with or without the DDT.

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THE main etiologic factor in the production of ingrowing toenails is shoe pressure with the help of nail deformity and infection.

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THEY are now recommending vitamin E in the form of ointment therapy for fibrositis. The direct application is said to be beneficially effective in relaxing the muscle fibers and prevents tissue injury through hydremia.

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HOUSING as well as food is a vital factor in child health and no one interested in public health can fail to realize the close connection between community health and community housing. But no one has the answer to the housing problem for our city folks with incomes of less than \$2000.00.—J. F.



# Allergic Sensitivity to Sulfonamide Drugs

HARRY N. HOLMES, Ph.D.

IN a recent issue of *Science*<sup>1</sup> the Subcommittee of the Committee on Public Health Relations of the New York Academy of Medicine opposed "over-the-counter" sales of all sulfonamide preparations, even of adhesive bandages containing only a few per cent of such drugs.

Their action was based on the increasing number of medical reports to the effect that "application of the sulfa drugs can arouse a hypersensitivity resembling an allergic phenomenon" so that on later occasions of desperate need sulfa therapy may become impossible. The Committee reported that a minute amount of a sulfonamide applied to the unbroken skin or to mucous membranes can and does sensitize an individual even more quickly and with greater certainty than if taken by mouth. This is alarming in view of the common practice of dusting a sulfa drug on wounds.

However, there is a remedy for possible cases of sensitization, not yet generally known but deserving extensive trial and criticism.

In my earlier paper,<sup>2</sup> "Hay Fever and Vitamin C" as well as in a later one,<sup>3</sup> "Food Allergies and Vitamin C", I showed the excellent therapeutic effect of daily oral doses of 200 mg. to 500 mg. (or more in severe cases) of vitamin C. If we wish to blame sulfa drugs for certain allergic reactions it would be logical to apply a similar treatment. This has already been done successfully.

I quote from correspondence with a few co-operating physicians and surgeons. Dr. Harold G. Kuehner, Mercy Hospital, Pittsburgh, wrote recently, "We have been using large doses of ascorbic acid with all our sulfonamide administration ever since this form of treatment was first started and we have had excellent results."

Dr. R. H. Aldrich, Boston City Hospital, wrote a year ago, "During the past eight months I have been using and advocating vitamin C as a detoxicant for various industrial poisons and in patients who needed sulfonamides but who were susceptible to them because of sensitization. I had one patient whom I had given sulfonamide for a streptococcus infection of her throat. She had become quite delirious and had a marked systemic reaction to the drug. She had a recurrence of her throat infection. By giving her 250 mg. of vitamin C daily I was able to put her on a second course of the sulfonamides with no untoward symptoms."

Dr. W. J. McCormick,<sup>4</sup> of Toronto, believes that symptoms of toxic reactions to sulfa drugs

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resemble those of vitamin C deficiency. When he observed a severe dermatitis after using a sulfa ointment on a sore he gave the patient 500 mg. of vitamin C daily for one week. Recovery was rapid. McCormick quotes Greene as observing that the toxic side effects of sulfathiazole are much more frequent in patients with toxic and febrile illness. This is logical because all infections lower the level of vitamin C in the patient.

Dr. J. H. Sharp reports the case of a five-year-old boy whose temperature, eight hours after treatment with sulfapyridine, rose to 106°. He was then given 50 mg. vitamin C with each dose of the drug. The temperature became normal in eighteen hours and the general improvement was astounding.

Dr. Hugh A. Kuhn, Hammond, Indiana, in treating a patient with sulfadiazine was obliged to hold the dosage to a low level due to a considerable drop in hemoglobin. After trying 250 mg. of vitamin C daily the patient was able to take three times the previous amount of sulfadiazine with no drop in hemoglobin, even after one month's treatment.

The use of vitamin C as a "detoxicant" followed publication of the paper,<sup>5</sup> "Lead Poisoning and Vitamin C", which may well have suggested the value of ascorbic acid in modifying the ill effects of arsenicals in syphilis. At any rate many physicians accompany such use of arsenicals with large doses of ascorbic acid. Carrying the analogy further Dr. Kuhn, finding a patient absolutely unable to take a certain bismuth preparation, gave her large oral doses of ascorbic acid (600 mg. to 300 mg. daily). She then took the bismuth with no discomfort. Another patient with severe dermatitis caused by a bismuth preparation was greatly relieved by 500 mg. vitamin C daily.

Dr. Robert E. S. Young, the medical director of the large Curtiss-Wright plant near Columbus, reported many cases of severe dermatitis among the workmen resulting in much loss of time and labor turnover. At my suggestion he gave 100

exposed workers 250 mg. of ascorbic acid (supported by some vitamins A and B<sub>1</sub>) every day. In one or two weeks 80 per cent of the men were free from the dermatitis. In other plants using certain plastics similar trouble has been found.

Aside from the small percentage of allergic responses to the sulfa drugs previously mentioned there is a more general weakness, often lasting for a discouragingly long time, following prolonged sulfa treatment. In an effort to explain this I persuaded a physician to give ten healthy students sulfathiazole for four days in amounts he would have given for a severe "strep throat". In every case the normal urinary excretion of vitamin C (24 hours) was approximately doubled. Since excessive loss of this vitamin results in weakness it would seem advisable to replace such loss by large doses of the vitamin. Furthermore I observed that sulfanilamide in the presence of vitamin C and oxygen slowly yields ammonia while the vitamin is destroyed. The formation of ammonia was not observed with three other common sulfa drugs under these conditions yet some other reaction to vitamin C may have occurred.

Acting on the theory that the level of vitamin C is lowered during sulfa drug treatment by forced excretion and, perhaps, by chemical reaction, six patients suffering from prolonged weakness were given 500 mg. of vitamin C daily. The quick return of normal vigor was surprising.

The manufacture of a few thousand tons yearly of sulfa drugs in this country confronts us with a major problem.

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### Poliomyelitis From Fly-Contaminated Food

Evidence has accumulated within recent years that the alimentary tract may be one of the most important portals of entry for poliomyelitis virus. The virus has been repeatedly demonstrated in human stools, in sewage and in flies collected in epidemic areas. Fly-contaminated food may thus be a theoretically logical source of human infection with polio virus. Experimental evidence in support of this hypothesis is reported by Ward and his associates of the Section of Preventive Medicine, Yale University School of Medicine.—W. H. Manwaring, M.D., Stanford Univ.; Calif. & West. Med., Vol. 63, No. 2, Aug., 1945.

### A Discussion of the Causes of Cancer

The second problem concerns the genetic constitution under which the predisposition to the development of cancer occurs. It is well known that mice can be so bred that the susceptibility to cancer is increased or decreased. Further facts are that the inheritance of each type of tumor is different and specific. In this intricate situation the development of the specific tissue patterns, for example, of carcinoma of the breast in mice, is similar to other genic effects such as size differences or resistance to disease, in which the conditions are sometimes simple and sometimes extremely complex. The predisposition to cancer in mice is not dominant nor a simple recessive; indeed in certain strains of mice breast tumors are not chromosomal but perhaps cytoplasmic in their inheritance.

In human beings the evidence is by no means so clear cut for reasons which are obvious. Human beings do not mate to please geneticists and most human beings do not know what killed their grandfathers or grandmothers. Human evidence comes partly from so-called cancer families in which a large number of the members develop the disease. A second source of evidence comes from twins in which case monozygotic twins yield a probability of 90% and dizygotic, 30% to 35%. There are many cases in the literature of identical twins who developed, for example, carcinoma of the same breast, in the same position, within a few months of each other. Further evidence is given in the work, particularly, of Madge Macklin which shows how statistically improbable the development of cancer is in many instances unless there is a genetic basis.

It is quite apparent that the theory of "chronic irritation" has occupied not only the center, but almost the entire stage for so long that the hereditary factors have been neglected. This is readily understandable, especially on the part of clinicians, some of whom are ready to accept the theory of "chronic irritation" as an established fact because they have witnessed an occasional tumor developing in the site of chronic irritation. This is not to decry the removal of foci of irritation such as infected cervixes, leg ulcers and a host of others but at least the mental reservation should be made that the direct relationship to cancer has no rigid proof as a generalization. This does not exclude "chronic irritation" as a selector of susceptibles but rather puts it in the proper perspective. . .

Reluctance to accept an hereditary basis in human beings is understandable also for there is nothing we can do about choosing our grandparents and thus avoiding the susceptibility and there is much that can be done about "chronic irritation".—Stanley P. Reimann, M.D., Philadelphia; Rhode Island Med. Jr., Vol. XXVIII, No. 8, Aug., 1945.



# Idiopathic Hypertrophy and Dilatation of the Esophagus\*

A. J. MANTILLA, M.D.

**Case History:** E.A., a 47 year old colored female, was first admitted to the University Hospitals in a semicomatose state. She had apparently been well until two weeks before at which time she developed pain in the right chest and right lower quadrant of the abdomen. A local physician prescribed sulfathiazole which was taken for four days. Following the use of this drug she began to vomit. The vomiting persisted and was exacerbated by eating and drinking. The volume of urine was markedly diminished during the four days preceding hospitalization. She became weaker and gradually lapsed into a semicomatose state. Past history revealed that she had been in the habit of regurgitating portions of her meals for a long time.

Physical examination revealed a stuporous, markedly dehydrated Negro female whose temperature was 36.1° C., pulse 114, and respirations 34. The blood pressure could not be obtained. The area of cardiac dullness was enlarged to the right. The heart sounds were normal. The lungs were clear to auscultation and percussion. Both ankles were extremely sensitive to palpation and motion. Aspiration of the right ankle joint revealed a small amount of cloudy fluid rich in polymorphonuclear neutrophils but no microorganisms were recovered. The urine had a specific gravity of 1.025 and a slight trace of albumin. The blood urea nitrogen was 234 mg./100 cc., the CO<sub>2</sub> combining power 34.5 volumes per cent, and the plasma chlorides 110 m. eq. There were 26,000 white blood cells per cubic millimeter, 5,010,000 red blood cells and 100 per cent hemoglobin (Sahli). The differential count showed 92 polymorphonuclear neutrophils and 8 lymphocytes. X-ray examination of the chest showed, in an anterior-posterior film, "a bizarre contour of the heart with a huge bulge to the right". The changes were at first thought to represent some type of congenital heart disease. However, fluoroscopic examination with the aid of barium revealed marked dilatation of the esophagus.

**Hospital Course:** The patient responded promptly to intravenous fluids. The urinary output was re-established and within five days the blood urea nitrogen had fallen to 16 mg./100 cc. Penicillin was administered and the joint pain disappeared. The patient refused surgical treatment and was discharged improved on the tenth hospital day to be followed in the Outpatient Department.

At home the patient remained in bed and continued to vomit small amounts of food. Two days later she vomited everything taken by mouth. Five days following her discharge from the hospital she became weak and lost consciousness. At this time she was re-admitted in coma. Her temperature was 39.9° C. The pulse and blood pressure were unobtainable. The clinical and laboratory signs were similar to those present on her first admission. The white blood cells were 16,000 per cubic millimeter, the red blood

cells 3,240,000 and the hemoglobin 70 per cent. The blood urea nitrogen was 118 mg./100 cc. The patient vomited large amounts of foul-smelling material with a strongly positive benzidine reaction. She failed to respond to treatment and died on her fifth hospital day.

**Autopsy:** (No. 8804.) This revealed marked dilatation and hypertrophy of the esophagus. The mucosa showed multiple hemorrhagic erosions and it contained approximately 500 cc. of dark brown fluid. In the first portion of the duodenum



Roentgenogram showing extreme enlargement of esophagus filled with opaque food, the shadow continuous with that of the heart.

there were two perforated acute ulcers. There was focal fibrino-hemorrhagic peritonitis with 275 cc. of fluid in the peritoneal cavity. The bloody vomitus present terminally can be explained either by the acute duodenal ulcers or by the hemorrhagic erosions of the esophagus. The lungs showed extensive bronchopneumonia which together with hemorrhage and peritonitis were responsible for the death of the patient.

## COMMENT

The exact mechanism of production of the hypertrophy and dilatation of the esophagus, which this case exemplifies, is not known. Various theories have been proposed by different authors. According to von Mikulicz the condition is caused by a spasm of the cardiac sphincter. Those authors in favor of this explanation refer to the condition as cardiospasm. However, a

\*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the twenty-ninth of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems".

true anatomical sphincter at this level has not been definitely demonstrated.

Kronecker and Meltzer showed that normally the cardia easily opens with each act of swallowing. Based on studies in a patient in which he could pass a stomach tube without resistance, Einhorn conceived the idea that the condition was due to a failure of the sphincter to open reflexly during the act of swallowing. Hurst demonstrated that the food travels down the esophagus, because of peristaltic waves. On reaching the cardia it enters the stomach through an active relaxation of the muscle at the lower end of the esophagus. A failure of this muscle to relax could result in hypertrophy and dilatation of the esophagus. Hurst introduced the term achalasia for this condition. Knight considered the condition to be analogous to Hirschsprung's disease which is due to an imbalance between the sympathetic and parasympathetic systems. Pollitzer claimed to have demonstrated lesions of the vagus nerve and Rake describes lesions of Auerbach's plexus. Lendrum in 10 cases in which adequate sections of the vagus nerves were studied failed to demonstrate any changes. The lesions reported in Auerbach's plexus could perhaps result from the chronic inflammation and pressure generally marked in such cases. Thus, it is extremely difficult to determine whether such lesions of nerves and ganglion cells are primary or secondary.

Of interest in this case was the marked extrarenal azotemia produced by the prolonged vomiting and dehydration. The capacity of the kidneys to concentrate the urine (specific gravity 1.025) and the dramatic response of intravenous fluids permitted the correct interpretation of the nature of the uremia.

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In the past twenty-five years the infant mortality rate for the United States has been cut in half. Despite this fact, in 1942, the last year for which figures are available, there were 2,888,170 deliveries in this country with 79,174 stillbirths and 113,492 infant deaths. The number of infant deaths in this country is more than twice as great as the number of men killed in our armed forces from the beginning of the present war to the present time.—Robert R. MacDonald, M.D., Pittsburgh, Pa.

## Kidney Function

The easily performed maximum-concentration test is the most sensitive of the gross tests of kidney function. Impaired concentrating ability was the sole abnormality in 19 per cent of the series, while impaired urea clearance occurred as the only abnormality in only two per cent and abnormal urinalyses occurred as the only abnormality in only 3.5 per cent. Freyberg, Ellis and Weiss, and Van Slyke have previously pointed out that the test of choice is the concentration test, that the concentrating function of the tubules is apt to show damage when the filtering function of the glomeruli does not. But it must be remembered, as Van Slyke has demonstrated, that as renal damage progresses, the urine specific gravity soon reaches a fixed, bottom level of 1.009 to 1.012, and that one must use the urea clearance test to indicate changes in the more severe degrees of kidney damage.

The results of this study corroborate Van Slyke's findings and statement that it is unnecessary to measure the urea clearance when concentrating ability is normal.

Corcoran and Page have also shown that a decrease in maximum concentrating power occurs in most patients with hypertension months before urea clearance falls to abnormal values. They explain that this is due to intense efferent arteriolar vasoconstriction producing an increased filtration pressure which squeezes more urea through the glomeruli, and thus urea clearance may be maintained at a normal rate despite the decreased renal blood flow in the hypertensive.

We realize that the tests of the exact mechanisms involved in kidney function—such as the determinations of total effective renal blood flow, rate of glomerular filtration, maximal tubular excretory capacity, and maximal tubular reabsorptive capacity—are more accurate and will show impairment earlier than the tests used in this series. But they are time-consuming tests requiring technical assistance for their performance; at present their use is limited to special, experimental studies on patients. The clinician following a case of hypertension may safely rely on the combination of urinalysis and concentration test to render a fairly accurate picture of the patient's renal status.

The combination of normal maximum concentrating ability and normal urinalysis is a sufficient clinical indication of unimpaired renal function.—Emil M. Isberg, M.D., Miami Beach, Fla., and Paul S. Barker, M.D., Ann Arbor, Mich.; *Jr. of Mich. State Med. Soc.*, Vol. 44, No. 8, Aug., 1945.



# Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

## NONTUBERCULOUS PULMONARY CALCIFICATION AND SENSITIVITY TO HISTOPLASMIN

IN different parts of the country, there are marked variations in the frequency of pulmonary calcification observed in roentgenograms of the chest. Recent studies have shown that the prevalence of calcified lesions varies from six per cent in Oregon to 28 per cent in Kentucky. An area of high prevalence occurs in the East Central States, with a frequency generally lower in surrounding regions. Roentgenographic findings have been the basis for rejecting appreciable numbers of persons from the armed services.

The question of tuberculin negative pulmonary calcification has been studied recently in an extensive investigation on tuberculosis in student nurses, which is being conducted cooperatively by the National Tuberculosis Association, the U. S. Public Health Service, and a large number of specialists throughout the country. About 10,000 student nurses are under close observation, and are given tuberculin tests and 14" x 17" chest X-rays at six-month intervals. The schools are sixty-five in number, and are located in nine widely distributed metropolitan centers. Results from the study bring out clearly the regional differences in the frequency of pulmonary calcification, as well as the fact that especially in the East Central part of the country, the majority of nurses with calcification have negative tuberculin reactions.

In order to investigate the possibility that infection with *Histoplasma capsulatum* may be a cause of pulmonary calcification, a large number of nurses were given intradermal histoplasmin tests. Preliminary data are based on records of these tests, roentgenograms, and tuberculin tests of 3,105 student nurses in four centers. Results of this work indicate that (a) infection with histoplasma, or an immunologically related organism, is common in widespread localities, and that (b) it is probably the principal nontuberculous cause of pulmonary calcification. These conclusions are based on the assumption that skin sensitivity to the histoplasmin used in this study is indicative of infection with *Histoplasma*.

All skin tests were performed and read by one person, and all films were interpreted by one experienced roentgenologist. Film findings are limited to a report as to the presence or absence of shadows characteristic of calcification in the lung parenchyma or lymph nodes. The interpretation was recorded without knowledge of the tuberculin reaction and prior to the testing with histoplasmin.

Most of the nurses tested were given tuberculin and histoplasmin at the same time, and measurements of both erythema and induration were recorded at 48 hours. The reactions to the two tests were similar and could not be distinguished by their appearance.

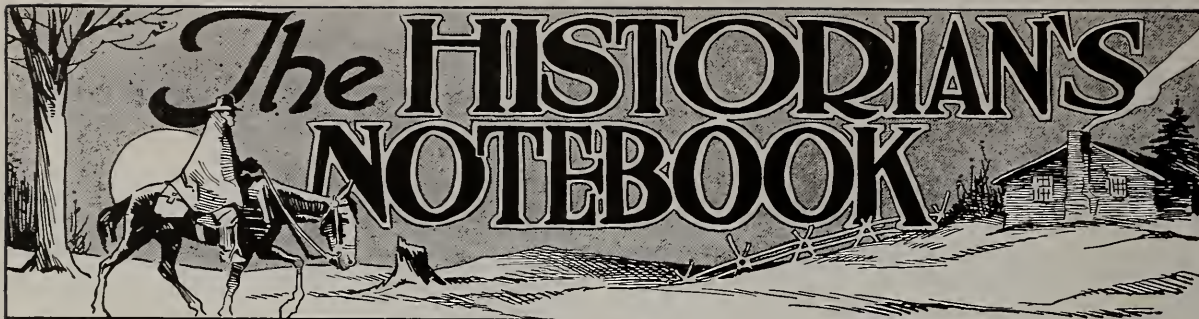
Of the 3,015 nurses studied, 711 (22.9 per cent) showed a positive reaction and 61 (2.0 per cent) a doubtful reaction to histoplasmin. Great differences were found in the percentage of nurses reacting to histoplasmin in the various cities. In Minneapolis and St. Paul, the percentage of definite or doubtful reactions was 6.3; in Philadelphia, 12.6; in Detroit, 14.4; in Kansas City, Kansas, 54.0; and in Kansas City, Missouri, 65.8.

The most striking findings in the investigation are derived from the study of the relation, in individual nurses, between pulmonary calcification and reaction to histoplasmin and tuberculin tests.

About one-fifth (21.4 per cent) of the total group of 294 nurses with calcification had a positive tuberculin. Of the remaining four-fifths (231), who had a negative tuberculin, 206 had a positive or doubtful histoplasmin reaction. Only 25 nurses (8.5 per cent of the 294 with calcification) had a negative reaction to both tests. From these findings it may be seen that a high proportion of the group having pulmonary calcification react to histoplasmin, tuberculin, or both (91.5 per cent), and that many more react to histoplasmin than tuberculin.

Of the nurses who react only to the latter, 10.4 per cent show pulmonary calcification, while of those reacting only to histoplasmin, 31.1 per cent show calcification. A very low rate of pulmonary calcification (1.2 per cent) is found among the large group of 2,141 nurses who are negative to both tests.

Perhaps it is premature at the present time to discuss the significance of the general findings presented in this paper. If the histoplasmin test is correctly interpreted, however, a number of implications become apparent. Histoplasmosis, in a mild, perhaps subclinical form, may be a common infection in the East Central States, and the number of persons attacked may total several million. The epidemiological evidence indicates that a high proportion of the pulmonary calcification observed in individuals living in these States may be due to infection with *Histoplasma* or a related organism, and not to tuberculosis. Nontuberculous Pulmonary Calcification and Sensitivity to Histoplasmin, Carroll E. Palmer, M.D., Public Health Reports, Vol. 60, p. 513, May 11, 1945.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## The Story of a Country Medical College

A BOOK REVIEW BY JONATHAN FORMAN, B.A., M.D.

DURING pioneer days, a good number of medical schools were started in this country in country villages and towns. Among these were: Transylvania University at Lexington, Kentucky (1799); Dartmouth at Hanover, New Hampshire (1798); The Fairfield School at Fairfield, New York (1812); The Castleton Medical Academy, Castleton, Vermont (1818); the Medical Department of Bowdoin College, Brunswick, Maine (1820); the Medical Department of the University of Vermont, Burlington, Vermont (1822); Berkshire Medical Institution at Plainfield, Massachusetts (1823); the Medical College of the Valley of Virginia and the Winchester Medical College, both in Winchester, Virginia (1827); the Medical Department of the University of Virginia at Charlottesville, Virginia (1827); and the Clinical School of Medicine at Woodstock, Vermont (1827).

### THE WOODSTOCK SCHOOL

It is about this Woodstock School that Frederick Clayton Wait, Ph.D., Emeritus Professor of Histology at Western Reserve University, has just published a book [*The Story of a Country Medical College—Vermont Historical Society, Montpelier, Vermont*]. This is the first detailed history of any country medical college to be published.

Since these country medical schools were an important feature in medical education in the middle of the Nineteenth Century and few modern medical educators and even fewer physicians have had an opportunity to learn much of the history of any such medical colleges, it is well

that in this well-written volume we now have assembled for us the information necessary to understand them.

Dr. Waite has collected all of the records of the school—the papers of incorporation, lists of trustees, faculty members, visitors, its 1,400 graduates and students, most of whom have been followed to their graves. A collection like this represents a stupendous task which is of great value to those who find American medical history worthy of pursuit.

After an excellent essay on "Early American Medical Education", Dr. Waite gives many "explanations" which make quite clear many of the things that took place in another country school—our own Willoughby School. The traditional seven divisions of medicine each represented by a chair in the faculty; the seasonal variation brought about because of the source of the professors; and this in turn giving rise to the peripatetic teacher followed by the migration of students.

### GRADED COURSES

Many who read that a man was required to attend the same lectures wonder about this repetitive curriculum and why it came about. It, however, makes sense when we see that such a curriculum was integrated into the preceptor system. The young man was supposed to read medicine and study osteology with his preceptor and then go to some medical school for a session of lectures of approximately 12 weeks. He was then to return to his preceptor and correlate what he had learned with what he saw and heard in his preceptor's office. At the end of the third year, he was supposed to attend another set of lectures for a session also of 12 weeks, present a thesis, pass the final examination, and be graduated with the M.D. degree.

NOTE: Dr. Jonathan Forman has served for many years as Chairman of the Committee on Medical History and Archives of the Ohio Archaeological and Historical Society, is a member of the American Association of Medical History, and a Professor of the History of Medicine in the Ohio State University.



With the fund of empirical knowledge and the small amount of science to be taught, this system was most satisfactory.

The Woodstock School was founded by Joseph A. Gallup, M.D., one of the outstanding physicians of his time. He was a man with advanced ideas. He wanted above everything else to institute clinical instruction in his new medical college. To do this he planned an infirmary to be owned and operated by the faculty. This was years ahead of the times and proved too advanced even for the young men with whom he had surrounded himself. They could not envision the great future that might have been theirs. They could not see that by entering into a cooperative agreement with the Berkshire Medical Institute of Pittsfield, Massachusetts, that they might become well-known and well-paid peripatetic professors. Had they had more vision, there might be today at Woodstock, Vermont, a great medical center such as we see at Rochester, Minnesota; Iowa City; Ann Arbor; Durham, North Carolina; or Charlottesville, Virginia.

Their college, however, did not perish for a lack of vision. They went on, after the founder gave up in his discouragement, to do a good job as a teaching institution. These men and those who joined the faculty later were almost all above the average. The school was progressive and many of its teaching methods were ahead of those employed in the larger centers; one example being the use of vivisection in the teaching of physiology. The total record of the school is highly commendable.

The struggle to get a charter from the Legislature in the face of the opposition, the petty fights of the faculty, the anatomical riots, the struggle of the dean to lead and mold into a harmonious unit the faculty of prima donnas, the costs of building, the financing of the school, all follow a pattern with which many of us are familiar.

#### THE DECLINE

This country medical college finally went into decline along with most of the others because everyone became aware of the need for formal clinical instruction. So this college and most of those like it died because they did not and often could not provide the very thing for which Dr. Gallup founded this particular school. If the founder could have convinced his younger colleagues it could have been provided at Woodstock in all probability.

Among the other factors which also contributed to the decline of country medical colleges, Dr. Waite enumerates the discovery of ether with its glorification of the surgeon and his workshop, the hospital; the organization of the American Medical Association under the lead-

ership of metropolitan physicians; and the advancement of methods of communication and travel with the migration of many to the cities. Finally, money became freer about 1850 and young men who wanted to go to the city to study could now afford it.

May I suggest this book as a present for that colleague for whom you would like to do the nice thing?

#### Army Establishes Seven Centers for Tropical Skin Diseases

Establishment of seven centers specializing in the treatment of tropical skin diseases has been announced by Major General Norman T. Kirk, Surgeon General of the Army.

The centers, it was explained by Major Clarence S. Livingood, of Philadelphia, consultant in dermatology to General Kirk, will be devoted to the care of men returned from overseas, particularly the Pacific areas.

The centers will be at Wakeman General Hospital, Camp Atterbury, Indiana; Brooke General Hospital, Fort Sam Houston, Texas; Moore General Hospital, Swannanoa, North Carolina; Harmon General Hospital, Longview, Texas; and in the U. S. Army General Hospitals at Camp Edwards, near Boston, Massachusetts; Camp Butner, near Durham, North Carolina; and Camp Carson, near Colorado Springs, Colorado.

Major Livingood said that there is no basis for fear of tropical skin infections spreading in this country, because practically none of these diseases are contagious and no patient with a transmissible skin disease would be allowed out of an Army hospital until he was noninfectious.

Acne was given as an example of a common skin disease which flares up in the tropics. One Army doctor working on the problem used the word "explosive" in describing the cases he had seen in the Pacific.

"The skin diseases are not fully appreciated by the public in the glare of the more dramatic developments of surgery and problems like malaria", Major Livingood said. "But it is true that in tropical areas about eight per cent of all Army hospital admissions—or one in every 12 or 13—is due to skin conditions."

One of the dermatologist's main efforts, Major Livingood said, is to keep men from "overtreating" skin disease; but the good nutritional state of the American soldier helps protect him from some of the skin diseases common to natives of tropical areas. Major Livingood cited tropical ulcer as an example, saying ulcerations were frequent enough among Americans, but the peculiar tropical ulcer is rare and he thinks that the native gets it because of his poor diet while the American is free of it because he is well fed.

# Point Systems for Release of Medical Officers Now In Effect; Future Work of Procurement and Assignment Service Reviewed; Medical Student Situation

**S**INCE August 19 when The Council of the Ohio State Medical Association adopted an official statement urging President Truman and other high government officials to expedite the release of medical officers in the Army and the Navy, steps which should bring about the early return of a large number of Ohio medical officers have been taken at Washington.

Following is a review of the situation as this issue of *The Journal* went to press and information regarding the future activities of the Procurement and Assignment Service for Physicians and of Selective Service.

**Release of Army Medical Officers**—On September 14, the War Department announced the details of a revised point system which, it is estimated, will return to civilian practice 13,000 physicians by January 1, 1946, and an additional 17,000 by June, 1946.

Undoubtedly a considerable number of Ohio physicians will become eligible for discharge under the modified point system.

Except for approximately 200 scarce medical specialists, any Army medical officer will be considered "surplus" and eligible for separation from the Army Medical Corps if he meets any one of the following conditions:

1. Has 80 or more discharge points;
2. Is 48 years of age or older;
3. Entered active duty prior to Pearl Harbor.

It is understood that point scores are computed on the following basis: One point for each month's service in the Army since September 16, 1940; one point for each month overseas; five points for each medal and campaign star; 12 points for each child under 18 years of age up to a maximum of three children.

An announcement by Maj. Gen. Norman T. Kirk, Surgeon General of the Army, stated that the "scarce specialists" would include specialists in eye, ear, nose and throat, plastic surgery, orthopedic surgery, neuropsychiatry and medical laboratory officers. General Kirk stated, however, that any of these specialists who was called to active duty prior to January 1, 1941, would be released at an early date.

General Kirk stated that in some cases essential officers now eligible for discharge may be retained by military necessity until replacements are shifted to their positions but none would be held in service after December 15, 1945, without their consent.

**Release of Navy Medical Officers**—A revised point system for discharges also has been put

into effect by the Navy Department which should bring about the early return of a good many Ohio doctors. This was effective September 15.

The Navy point system provides that a medical officer will be eligible for release if he has 60 points accrued as follows:

One-half point for each month of active duty since September 1, 1939; one-fourth point for each month of active duty outside the United States since September 1, 1939; one-half point for each year of age computed to nearest birthday; 10 points for one or more dependents.

In addition the Navy will consider for release to inactive status those officers who have been awarded any one of the following citations since September 1, 1939: Medal of Honor, Navy Cross, Army Distinguished Service Cross or Silver Star, and, if awarded for combat, the Legion of Merit or Distinguished Flying Cross.

There will be special dispensation for release to inactive status for those who are permanently limited by medical survey to shore duty as a result of service-incurred disabilities.

**Procurement and Assignment Activities**—A bulletin issued by the Washington office of the Procurement and Assignment Service for Physicians, War Manpower Commission, on September 7, stated that following conferences between the Directing Board and the Surgeons General of the Army and Navy it has been decided to continue the activities of the Procurement and Assignment Service with respect to supplying hospitals with interns and residents and to aiding areas in acute need of medical personnel for civilian services.

Following are reviews of the responsibilities and activities of the Procurement and Assignment Service in these two fields.

**9-9-9 Program To Be Continued**—The Army and Navy expect at this time to call to active duty as replacements all of their officers upon the completion of internship or residency and all their successors who have been educated at government expense under ASTP or V-12 programs.

Since the majority of students, interns and residents are Army or Navy personnel, the 9-9-9 program relating to interns and residents will be continued to insure a supply of residents for hospitals.

Because the supply of interns and residents will be limited, all hospitals will be expected to keep their house staffs within existing intern and resident quotas. In other words, hospitals will have the same intern and resident quotas and



will be allowed the same number of deferred officers for residencies for the period starting next April 1, 1946, and ending December 3, 1946, as those in effect for the present nine-month period, i.e., the period starting July 1, 1945.

The Directing Board has stated that if at any time in the interim it is possible to revert to peacetime internships and residencies, Procurement and Assignment controls will be withdrawn at once.

It has been pointed out to all hospitals that the provision by which discharged veterans can take residencies without being counted in quotas during the first period of their service should bring some relief and enable hospitals to increase their house staffs.

**Release Program of P. and A. Service**—Although the Army and Navy have liberalized their point systems for the release of medical officers by which a large number of medical officers will become eligible for prompt discharge, the Surgeons General have indicated their readiness to cooperate with the Procurement and Assignment Service in the release of selected medical officers to meet critical community situations.

It was emphasized by both the Army and the Navy that the successful operation of such a program was dependent upon the submission for special consideration of only those cases where the community need is really critical and for those officers whose release is unlikely on any other basis, such as on points, undue hardship, etc.

Under instructions from Washington, the State Chairman of the Procurement and Assignment Service will be expected to submit for special consideration as to discharge, only those cases for which relief cannot be otherwise secured. In other words, if a medical officer has a sufficient number of points to be eligible for discharge under the Army or Navy point system, he will be expected to apply for release under that method rather than through the Procurement and Assignment Service on the basis of community need.

However, in event a medical officer does not have a sufficient number of points and there is a critical need for his services in civilian practice in an acute area, his case may be considered by the Procurement and Assignment chairman and recommendations for his release, accompanied by supporting data, may be submitted to the Appeal Committee of the Procurement and Assignment Service at Washington for review and forwarding to the War or Navy Department if favorably considered by the Appeal Committee.

The release of medical officers under the point system will undoubtedly be faster and more certain than on the grounds of urgent community need. For that reason, State Chairmen have been advised to confine their recommendations only to critical situations for which relief can not be obtained under the point system.

So far as Ohio is concerned, while it is a fact that no community is oversupplied with physicians for civilian practice at this time, according to Dr. Robert Conard, Ohio Procurement and Assignment Chairman, some areas are much worse off than others and because of this, consideration will have to be given at this time only to areas which are rated as acute by comparison. It is Dr. Conard's belief that most of the situations will be met in the near future through the routine discharge of physicians under the point system. Exceptional cases, however, will be given thorough consideration and appropriate action taken, he said.

**Demands for Early Demobilization**—According to newspaper reports, members of Congress have been flooded with requests from civilians for the

Under an executive order of September 20, President Truman transferred the Procurement and Assignment Service for Physicians, Dentists, Veterinarians and Nurses to the Office of the Federal Security Administrator. Heretofore this service had been operating under the War Manpower Commission which has been transferred to the Department of Labor.

early release of medical officers. These appeals apparently have had a beneficial effect as evidenced by the lowering of the point systems of both the Army and Navy and the issuance of statements that the release of medical officers will be expedited.

A copy of the statement on this question, adopted by The Council of the Ohio State Medical Association on August 19 (page 833, September, 1945, issue of *The Journal*), was transmitted to President Truman, the Secretary of War, the Secretary of the Navy, the Surgeons General of the Army and Navy and to the Ohio members of Congress.

Replying to this communication on behalf of the Surgeon General of the Army, Maj. Gen. George F. Lull, deputy surgeon general, referred to the Ohio State Medical Association's statement as "the fairest and the most logical that has passed over my desk in a long time". General Lull said that the Surgeon General is in complete accord with everything contained in the statement and predicted that a program to bring about the release of many medical officers would be announced in the near future. This program was subsequently put into effect.

Surgeon General of the Navy Ross T. McIntire acknowledged receipt of the statement and stated that everything possible is being done to release medical officers as rapidly as possible and that



the rate of release will be stepped up as time advances.

A similar letter was received from the Office of the Secretary of the Navy in which it was said that a substantial number of Navy medical officers would be returned to civilian status by January 30, 1946.

Replies pledging assistance in the matter of early discharge of medical officers were received from Senator Robert A. Taft and Congressmen Clarence J. Brown, J. Harry McGregor, Robert F. Jones, John M. Vorys, Earl R. Lewis, P. W. Griffiths, and George H. Bender.

Congressman Brown, under date of August 23, dispatched a letter to the Secretary of War emphasizing the need for prompt action in releasing medical officers and for decreasing the point system which was in effect at that time.

Ohio members of Congress also were memorialized by the Ohio Senate in special session on September 5 to "take steps as will effectuate a prompt return of a reasonable number of doctors to their home communities and take such action as will immediately provide a supply of medical students to meet the growing shortage which will accelerate over the next five years". The resolution was introduced by State Senator Theodore M. Gray, Piqua, and was adopted by a unanimous vote.

**Situation Regarding Medical Students**—The situation regarding medical students and medical education continues in a somewhat confused state. Medical schools are having little difficulty in filling their freshman classes this Fall, but they are rather pessimistic regarding conditions in 1946, 1947 and 1948 due to the policy of Selective Service for the past 18 months of inducting premedical students.

Through a promotional campaign sponsored by the Procurement and Assignment Service, War Manpower Commission, efforts are being made to find among veterans now being discharged those who are qualified and interested in continuation of their preprofessional and professional training. It is too early to know what results this campaign will produce.

The efforts being made to enroll discharged veterans in medical schools have been counteracted to some extent by enrollment by the Army and Navy of more than 1,000 service men as first year medical students. This has limited the number of openings in the medical schools for some of the discharged veterans who are being encouraged by the Procurement and Assignment Service to enter medical training.

The situation is summed up in a Washington Letter, published in *The Journal of the American Medical Association*, as follows:

"The Army and Navy have enrolled more than 1,000 service men as first year medical students. This action is said to have been taken because of commitments to the schools and to the men.

The services will probably keep them in school for only one semester. The Navy announced that, although its V-12 program will be liquidated starting November 1, 1,500 V-12 students are entering medical and dental schools for one year. The majority are enrolled in medicine. The Army has 400 enrolling in medical schools this Fall under the Army Specialized Training Program. Some 5,700 other medical and 1,450 dental students in the Navy V-12 program will remain on active duty until the end of the semester now current or starting before November 1. An Army spokesman said that the Army was obligated under the act setting up the Specialized Training Program to continue it until Congress calls a halt. Veterans, meantime, complain that they have been told they can not get into medical school under the G. I. bill for a year or more because schools are full. A representative of the War Manpower Commission Procurement and Assignment board estimates that 75 to 80 per cent of Federal schools are occupied by Army and Navy students. Ten days ago the WMC announced plans 'to enroll immediately 12,000 students for medical, dental, premedical and predental courses beginning this Fall from among veterans now being discharged from the armed forces'. This recent check discloses that medical schools are filled and can not take the large number of students the WMC said could be enrolled."

**Selective Service Rules Relaxed**—Relaxing of Selective Service regulations applying to induction of medical students will have a tendency to alleviate the situation somewhat, although it is pointed out by some that the action comes "after the horse has been stolen".

Under date of August 31, Selective Service Local Board Memorandum No. 115 was amended and transmitted to local boards as a guide with respect to deferment of certain classes of students. The following recommendation is made:

3. Special consideration for registrants ages 18 through 25 in certain activities: Local boards will give special consideration to the deferment of registrants for whom there is on file or is hereafter filed a Form 42A (Special—Revised) if they come within one of the groups described as follows:

(a) Students in medicine, dentistry, veterinary medicine or osteopathy: Registrants ages 18 through 25 for whom a Form 42A (Special—Revised) is filed and in whose case the local board determines that they are pursuing a full-time course of study in medicine, dentistry, veterinary medicine or osteopathy in a recognized school of medicine, dentistry or veterinary medicine or osteopathy until their graduation, and that they have completed a satisfactory preprofessional course prior to their entrance, will be given special consideration provided that a student of veterinary medicine should not be considered for occupational deferment if he commenced the study of veterinary medicine in a school of veterinary medicine on or after March 15, 1945. A "satisfactory preprofessional course" shall mean such work as is ordinarily required for entrance by medical, dental, veterinary medicine, and osteopathy schools of good reputation.

At the same time the central office of the Procurement and Assignment Service announced the discontinuance as of Sept. 15, 1945, of the plan for certification by state chairmen of registrants



aged 18 through 25. Under the present Selective Service policy the deferment of registrants 26 years of age or more will be practically automatic.

**Status of V-12 Navy Students**—Changes in the status of a considerable number of Navy V-12 students, some of whom are in medicine, was announced recently by the Navy Department.

Approximately 8,500 students in the Navy V-12 program pursuing medical, dental, theological, premedical, predental and pretheological training will start returning to inactive duty on November 1. The remaining 25,500 students in the Navy V-12 program will either graduate or continue their training in college as apprentice seamen on active duty. Final disposition of all students in the program will be made by June, 1946.

As previously announced, V-2 training at 69 of the 124 colleges and universities throughout the country with V-12 and NROTC units will terminate on November 1. Training will continue at 42 NROTC units and 13 V-12 units in the program and at 10 newly established NROTC units.

Approximately 5,700 medical and 1,450 dental students will remain on active duty until the end of the semester now current or starting before November 1. Another 1,500 V-12 students entering medical or dental school this Fall will remain on active duty for one term. Medical and dental students will be returned to inactive duty as enlisted men and will subsequently receive probationary commissions in the Naval Reserve and be retained on inactive duty.

A total of 250 theological and 95 pretheological students will return to inactive duty as enlisted men at the end of the academic term now current or starting before November 1. Later those eligible will receive probationary commissions as ensigns in the Naval Reserve and be retained on inactive duty.

There are 1,056 premedical and predental students in the program who will return to inactive duty as apprentice seamen at the end of the current academic term on November 1.

V-12 trainees now enrolled in the NROTC or who are scheduled to be so enrolled on or before November 1 will be retained under instruction on active duty until June, 1946, unless they become eligible for commissions or discharge from the service at an earlier date. Students specializing in engineering will continue their training after November 1 in the Navy V-12 program as scheduled. Marine Corps students in the V-12 Program will continue their training after November 1.

Students in the Naval Aviation Preparatory Program who are either in college training now or who are scheduled to enter the program on or before November 1 will be retained under instruction on active duty.

### Conference on Tuberculosis

A Conference on Control of Tuberculosis in a Metropolitan Area, sponsored by the Institute of Medicine of Chicago, will be held on Tuesday and Wednesday, November 13 and 14, 1945, at the Palmer House, Chicago, and will cover phases that are of particular importance at this time to clinicians, specialists, lay workers, and teachers, who are cordially invited to attend.

### A.M.A. HOUSE OF DELEGATES CALLED TO MEET IN CHICAGO, DEC. 3-6

The annual meeting of the House of Delegates of the American Medical Association will be held in Chicago for four days, beginning December 3.

The annual session usually is held in June, but was delayed this year because of wartime travel restrictions. The meeting, which will be held in the Palmer House, is expected to bring together approximately 200 delegates and officials of the Association.

During the session, Dr. Kretschmer will relinquish the presidency of the Association and will be succeeded by Roger Irving Lee, M.D., of Boston, who was chosen president-elect at the wartime session of the A. M. A., which was held in Chicago in June, 1944.

Because of the war, the annual A. M. A. convention could not be held in New York this year. San Francisco was selected some years ago to play host to the June, 1946, convention.

### Schering Corporation Appoints New Sales and Promotion Heads

Schering Corporation, manufacturers of endocrine and pharmaceutical preparations, having offices in Bloomfield and plants in Bloomfield and Union, New Jersey, has appointed Dr. John N. McDonnell to the newly created post of Director of Domestic Sales and Promotion, succeeding Mr. Arthur F. Peterson, Manager of Domestic Sales Division, who has resigned. Herman W. Leitzow, eastern division manager since 1944, has been made assistant to Dr. McDonnell. George C. Straayer, manager of the professional service division, will continue in that post and in addition will devote part of his time to the development of field operations for Schering. Dr. McDonnell has for the past four years been head of research of the Drugs Branch of the War Production Board and was recently national director of civilian penicillin distribution. Dr. McDonnell is editor of *American Professional Pharmacist* magazine of New York and a member of the faculty of pharmacy and business at the Philadelphia College of Pharmacy and Science.

Due to transportation difficulties, the examinations of the American Board of Ophthalmology, scheduled for Chicago in October, have been postponed to Jan. 18-22, 1946. Communications for the Board should be addressed c/o Cape Cottage, Maine.

# Officers Elected by Board of Ohio Medical Indemnity, Inc.; Authorization to Start Business Expected Soon

**F**IRST meeting of the Board of Directors of Ohio Medical Indemnity, Inc., organized through the initiative of the Ohio State Medical Association and eight of Ohio's Blue Cross Hospital Service Associations to provide cash indemnities against medical, surgical and obstetrical expenses, was held in Columbus on September 5.



L. H. SCHRIVER

Personnel of the Board of Directors, elected at the first stockholders' meeting on August 19, was published in the September issue of *The Journal*, page 836.

At the first directors' meeting, the following officers and officials were elected:

**President:** L. H. Schriver, M. D., Cincinnati, president of the Ohio State Medical Association.

**Vice-president:** Mr. James E. Stuart, executive vice-president, Hospital Care Corporation, Cincinnati.

**Vice-president:** Mr. Ralph W. Jordan, director, Central Hospital Service, Columbus.

**Executive vice-president:** Mr. Charles H. Coghlan, Columbus, formerly assistant director, Michigan Medical Service.

**Secretary-Treasurer:** Mr. Charles S. Nelson, Columbus, executive secretary, Ohio State Medical Association.

**General Counsel:** Mr. Wayne E. Stichter, Toledo, member of the law firm of Effler, Eastman, Stichter and Smith.

Pursuant to a resolution passed by the Board of Directors, authorizing the president to appoint an Executive Committee with the approval of the board, consisting of eight directors, President Schriver named the following as members of the Executive Committee:

Carll S. Mundy, M. D., Toledo, Chairman;

Robert C. Rothenberg, M. D., Cincinnati;

C. C. Sherburne, M. D., Columbus;

William M. Skipp, M. D., Youngstown;

R. K. Finley, M. D., Dayton;

Edgar P. McNamee, M. D., Cleveland;

The Most Reverend Karl J. Alter, D. D., Toledo;

Mr. E. C. Pohlman, Columbus.

Under the Code of Regulations of the company, the President, Executive Vice-President, and

Secretary-Treasurer are ex-officio members of the Executive Committee without the right to vote.

The Executive Committee is empowered to have and exercise, in the interval between the meetings of the Board of Directors, all the powers of the Board in the management, business and affairs of the corporation, acting under the direction and control of the Board and reporting its actions and proceedings to the Board.

By action of the Board, the Huntington National Bank, Columbus, was designated as the depository of the company; arrangements were made for the bonding of officers; the Executive Committee was authorized to prepare a final draft of the contract of insurance to be sold by the company for submission to the Superintendent of Insurance preliminary to securing an authorization to transact business; and the committee was instructed to confer with representatives of the Blue Cross Hospital Service Associations on the provisions of a working agreement relating to acquisition, promotional, administrative and clerical activities and the apportionment of the costs of carrying on such activities.

As this issue of *The Journal* went to press, arrangements were being made for a meeting of the Executive Committee at which it is hoped the insurance contract and rates will be approved.



CHARLES H. COGHLAN

Present plans indicate that the solicitation of subscribers will be started in the area covered by the Hospital Care Corporation, Cincinnati.

The officers and members of the Board of Directors of Ohio Medical Indemnity, Inc., consider the company extremely fortunate in having been able to secure the services of Mr. Coghlan as Executive Vice-President. In that capacity, he will be the full-time administrative officer of the company and director of the home offices of the company which will be maintained in Columbus.

Mr. Coghlan has had considerable experience in the general insurance field and in the special-



ized field of prepayment coverage for medical and surgical expenses. His insurance background dates back to 1928 the year he received his B. A. degree from St. Bonaventure College, Allegany, N. Y. At that time he affiliated with insurance companies in the states of New York and Michigan and later entered general agency work with the D. F. Broderwick Agency, Detroit.

In March, 1940, Mr. Coghlan joined Michigan Medical Service as assistant director. In that capacity he had an active part in making Michigan Medical Service the largest and strongest prepayment medical service plan in the country and comes directly from that position to Ohio to become the chief administrative officer of Ohio Medical Indemnity, Inc.

### Emergency Medical Care of Army Personnel While on Leave

The War Department calls attention to the procedure to be followed by civilian physicians and hospitals for the emergency medical care of Army personnel home on leave or furlough.

When possible, such personnel should be referred to the nearest Federal medical installation for care and treatment. If the condition of the patient is such that immediate treatment or hospitalization is necessary, civilian medical attendance is authorized at public expense under existing regulations. This does not apply to Army personnel who are A.W.O.L., or to those who obtain elective medical treatment in civilian hospitals or by civilian physicians.

In case of emergency treatment or hospitalization, the individual or his attending physician should notify the appropriate service command surgeon. In Ohio the address is: Headquarters, Fifth Service Command, Fort Hayes, Columbus 18.

The following information must be furnished: full name; military rank; army serial number; military address, including organization and home station (orders in possession of military personnel will give this information); diagnosis; estimated duration of treatment and approximate date when patient's condition will permit transfer to an Army hospital if hospitalization is required.

All bills for medical treatment or hospitalization in Ohio should be submitted to the Service Command Surgeon at Fort Hayes and must show the soldier's name, rank, serial number, organization and home station.

Dr. John E. Davis, Columbus, has been appointed dental consultant in the Medical Section of the State Industrial Commission. He was associated for four years with the dental division of the State Department of Health.

### DON'T FORGET - - -

Remember that the provisions of Senate Bill 90, the prenatal examination law, are now in effect. The effective date was August 22.

Under this new law, a physician attending a pregnant woman must take, or cause to be taken, within 10 days of the time of the first examination of the woman, a specimen of blood for a serologic test for syphilis, unless the woman refuses to submit to such test. A statement that the test was taken, or the reasons why it was not, must be made on the birth report.

For complete details of the provisions of the law, see page 736, August, 1945, issue, The Ohio State Medical Journal.

### Contributions Totalling \$16,589,874 Made To Infantile Paralysis Fund

Topping last year's unprecedented donations by more than 50 per cent, the American people contributed \$16,589,874 to the 1945 March of Dimes of The National Foundation for Infantile Paralysis, as against \$10,793,491 for 1944. Ohioans donated \$860,758.55 in 1945. Of the total amount of funds raised, 50 per cent is allocated to national headquarters of the Foundation to finance research in the cure and prevention of infantile paralysis and a broad educational program which includes scholarships and fellowships in orthopedic nursing, physical therapy, orthopedic surgery, virology and health education, as well as to maintain an emergency epidemic fund to aid county chapters in areas hard hit by outbreaks of the disease. The other half of the March of Dimes' funds is retained by county chapters to carry on services to infantile paralysis victims in the 3,070 counties of the United States. The United States had its second largest epidemic of infantile paralysis in 1944 with a total of 19,272 cases. Of these, 1,172 occurred in Ohio.

Last year, 4,007 industrial employees 17 years of age or younger, filed claims with the State Industrial Commission for injuries or occupational diseases which caused loss of time of one or more days. Included in the number were 13 fatalities and 120 permanent partial disabilities.

# Stark County Postgraduate Assembly To Be Held Oct. 17; Toledo To Be Scene of Northwestern Ohio Meeting, Oct. 9 and Annual Toledo U. Institute on Nov. 2

END of the war has brought about the resumption of postgraduate medical meetings in Ohio. First of the series of medical assemblies which undoubtedly will be held throughout the state during the Winter and next Spring are the Stark County Medical Society Postgraduate Assembly, to be held at Canton on October 17, the traditional Northwestern Ohio Medical Society Meeting to be held at Toledo on October 9 and the Annual Toledo Postgraduate Day on November 2. Details regarding these three meetings, to which all Ohio physicians are invited, follow:

THE Stark County Medical Society will present a Postgraduate Assembly in the air-conditioned ballroom of the Onesto Hotel, Canton, Wednesday, October 17.

The program will be presented by three members of the faculty of the University of Cincinnati College of Medicine, Dr. M. A. Blankenhorn, Dr. Max M. Zinninger and Dr. William A. Altemeier.

Registration will open at 9:00 A. M. The registration fee of \$5.00 will include a steak dinner at 6:00 P. M.

The morning program will open at 10:00 A. M., lasting until 11:30 A. M. One of the features of the morning session will be diagnostic clinics and demonstration of patients.

The afternoon session will start at 1:00 P. M., recessing at 4:30 P. M. After the steak dinner at 6:00 P. M. there will be an evening session, starting at 7:30 P. M.

Members of the Stark County Medical Society have arranged this assembly to help fill the gap until state and national medical meetings can be resumed.

All Ohio physicians are cordially invited to attend, regardless of place of residence.

Inquiries concerning the meeting and reservations for the dinner should be addressed to the secretary of the society, Dr. L. E. Anderson, Greentown.

It is anticipated that a number of representatives of pharmaceutical and surgical supply companies will be present with interesting exhibits.

The complete program for the assembly follows:

## MORNING SESSION

- 9:00 A. M.—Registration.
- 10:00 to 10:45 A. M.—Diagnostic clinics and demonstrations, Dr. Blankenhorn.
- 10:45 to 11:30 A. M.—“Penicillin in the Treatment of Wounds of Violence”, Dr. Altemeier, to be followed by the showing of three reels of motion pictures just completed by the

University of Cincinnati College of Medicine faculty.

11:30 A. M. to 1:00 P. M.—Luncheon. (No organized luncheon has been arranged.)

## AFTERNOON SESSION

- 1:00 to 1:45 P. M.—“Postoperative Complications: Their Prevention and Treatment”, Dr. Zinninger.
- 1:45 to 2:30 P. M.—“Cause of Death in Pneumococcus Pneumonia. What To Do About It”, Dr. Blankenhorn.
- 2:30 to 3:00 P. M.—Recess.
- 3:00 to 3:30 P. M.—“Penicillin in the Treatment of Acute Hematogenous Osteomyelitis”, Dr. Altemeier.
- 3:30 to 4:30 P. M.—Questions and Answers and Discussion Period directed by the guest speakers.
- 6:00 P. M.—Dinner.

## EVENING SESSION

- 7:30 to 8:15 P. M.—“Surgery in Patients with Jaundice”, Dr. Zinninger.
- 8:15 to 9:00 P. M.—“Diagnosis and Treatment of Obscure Fevers”, Dr. Blankenhorn.
- 9:00 P. M.—Adjournment.

## Fine Program Arranged For Northwestern Meeting

OHIO physicians are cordially invited to participate in the 101st Meeting of the Northwestern Ohio Medical Society, Tuesday, October 9, at the Commodore Perry Hotel, Toledo.

The morning session will begin at 10:30 o'clock with an address on “Obstetrical Helps”, by Dr. Charles O. McCormick, clinical professor of obstetrics, Indiana University School of Medicine. At 11:15 A. M., Dr. Carl E. Badgley, professor of surgery, in charge of the Orthopedic division,





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The demulcent smoothage effect of Metamucil makes it a valuable adjunct in the various forms of colitis—spastic, atonic and ulcerative.

The tendency of Metamucil to incorporate irritating particles within the intestinal residue assists materially in minimizing irritation of the inflamed mucosa.

*Smoothage* describes the gentle, non-irritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, *Plantago ovata* (50%), combined with dextrose (50%).

# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

University of Michigan Medical School, will speak on "Low Back Pain".

A luncheon has been arranged for 12 Noon, and the ladies are invited. The guest speaker will be Earl Grebe, news analyst for radio station WSPD, whose topic is "A Look Ahead". In addition, a short talk entitled "What Lies Ahead for the Medical Profession", will be given by Dr. Edward J. McCormick, Toledo, Chairman of the Council on Medical Service and Public Relations of the American Medical Association. Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., will discuss briefly the new insurance program of that company.

At 2:30 P. M., Dr. Edward L. Cornell, assistant professor of obstetrics, Northwestern University Medical School, will speak on "Diagnosis and Treatment of Vaginal and Rectal Itching".

The session will close with an address at 3:15 P. M. by Dr. Fred W. Dixon, assistant clinical professor of otolaryngology, Western Reserve University School of Medicine, on "Office Management of Sinusitis".

Officers of the Northwestern Ohio Medical Society are: Dr. M. W. Diethelm, Toledo, president; Dr. John M. Leahy, Tiffin, vice-president; Dr. Robert J. Semons, Carey, secretary and Dr. E. L. Brady, Marion, treasurer. The Councilors are: Dr. Guy E. Noble, St. Marys, Third District, and Dr. A. A. Brindley, Toledo, Fourth District.

### Toledo Postgraduate Day Scheduled for November 2

THE 12th Annual Toledo Postgraduate Day, under the auspices of the Medical Institute of the University of Toledo, will be held Friday, November 2., 1945. The University of Toledo will again be the host of the meeting which will be held in the Henry J. Doermann Theater.

Each year this postgraduate day is held in memory of a graduate of the old Toledo Medical School. This year it will be a memorial to Dr. J. G. Keller. Dr. Keller practiced urology in Toledo for many years.

The day will be divided into three sessions, morning, afternoon and evening, with a banquet at 6:30 P. M. in the University dining room.

The committee on arrangements consists of the following: W. W. Alderdyce, M.D., H. H. M. Bowman, Ph.D., Fred M. Douglass, M.D., E. Benj. Gillette, M.D., Barney J. Hein, M.D., Dale Wilson, M.D., Philip C. Nash, D.Sc.

Program details will be mailed to physicians in that area of Ohio at a later date.

A total of \$8,756,876 has been allotted by the Venereal Disease Division of the U. S. Public Health Service to the states and territories for venereal disease control for the fiscal year ending June 30, 1946. Ohio's share is \$257,885.

### Licensed Through Endorsement

The State Medical Board has granted licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states: Allan C. Barnes, Columbus, University of Michigan; Nicholas P. Dallis, Toledo, Temple University; Gerald H. Flamm, Cincinnati, Long Island College; Thornton G. Grimes, Springfield, Meharry Medical College; Innes C. Haines, Bellevue, University of Virginia; William H. Horner, Dayton, Yale University; William Kulka, Cleveland, University of Vienna; John R. LaManna, Youngstown, University of Louisville; William G. Leary, Jr., Cincinnati, University of Virginia; Edgar S. Lotspeich, Jr., Cincinnati, University of Louisville; Joseph C. Painter, Columbus, University of Pittsburgh; Nathan Poliakoff, Cincinnati, University of Georgia; Andrew B. Royal, Akron, Meharry Medical College; Anthony Santoro, Cleveland, Loyola University; Florence R. Santoro, Cleveland, Loyola University; John A. Scholl, Steubenville, University of Maryland; Charles J. Walker, Wyoming, Meharry Medical College; Walter L. Wheat, Dayton, Meharry Medical College; Thomas L. Grayson, Youngstown, University of Buffalo; Joseph C. Johannes, Westerville, College of Medical Evangelists; Walter Schiller, Toledo, University of Vienna; Leo J. Szary, Cincinnati, Hahnemann Medical College.

Otto O. Bettag, Springfield, Univ. of Iowa; Rozier E. Bland, Columbus, Meharry Medical College; Walter L. Bryant, Toledo, Univ. of Michigan; Francis S. Chance, Gallipolis, Univ. of Georgia; Joseph K. Doran, Cleveland, Univ. of Iowa; Harry Einhorn, Dayton, Anderson College of Medicine, Glasgow, Scotland; Norman A. Evensen, Cincinnati, Univ. of Colorado; Joseph L. Fink, Toledo, Univ. of Michigan; Abraham L. Framer, Jewett, Eclectic Medical College; Paul I. Geer, Wauseon, Univ. of Louisville; Joseph B. Gumper, Dayton, Creighton University; Pearl E. Hackman, Canton, Woman's Medical College of Pa.; Elmer Haynes, Toledo, Univ. of Arkansas; Thos. R. Hazelrigg, Cleveland, Duke University; Frederic B. House, Cleveland, Univ. of Michigan; Richard H. Jacques, Columbus, Jefferson Medical College; Joseph Lander, Wyoming, Yale University; James D. Mitchell, Zanesville, Meharry Medical College; Chas. W. Mockbee, Cincinnati, Tulane University; Eduard C. Reynolds, Cleveland, Bennett Medical College.

The late Dr. Edward C. Morrow, who practiced in Canton for 57 years, left a trust fund estimated in excess of \$400,000, the income to be shared equally by Aultman and Mercy Hospitals. He died August 26, 1945.



## Self-Insurers Must Pay Claims

Ohio employers carrying their own Workmen's Compensation insurance, i.e., self-insurers, must not look to the state to pay employee death claims resulting from a catastrophe, the Ohio Supreme Court ruled on August 8. The decision was given in an action sponsored by the East Ohio Gas Company to compel the State Industrial Commission to pay death awards to dependents of 73 company employees who died in the liquid gas explosion at the company's Cleveland storage plant Oct. 20, 1944. The Industrial Commission refused to pay any of the claims, insisting that the company, being a self-insurer, must pay the claims itself. The widow of one of the explosion victims, sought by mandamus action in the Supreme Court to compel the state to pay her award. The Court decreed unanimously that there was no statutory authority for the state to pay such awards.

The Medical College of Alabama, Birmingham, opened officially June 4 with instruction of a junior class. Established by action of the 1943 state legislature as a division of the University of Alabama, the college will absorb the School of Basic Medical Sciences on the university campus, where the first and second years of medicine have been given since 1920.

### CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line, payable in advance. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

**WANTED:** Resident physician, male or female, for sanatorium; salary \$3,000 per annum. Will sell interest in business to properly qualified physician. Write Stokes Sanatorium, Louisville, Ky.

**WANTED:** Physicians: good salary; institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne State School, Fort Wayne 1, Indiana.

**WANTED TO BUY:** "Atlas of Congenital Cardiac Disease", by M. E. Abbott. Write E. W. Miskall, M. D., East Liverpool.

**FOR SALE:** Physician's complete office equipment. Will rent office. Fine opportunity to take over practice of deceased physician. C. H. Shaw, D.D.S., Bremen, Ohio.

**FOR SALE, RENT OR LEASE:** Very active general practice. New office and home near Cincinnati. Unopposed. Specializing. W.E.T., care of Ohio State Medical Journal.

**FOR SALE:** Kelleket portable X-ray machine bought in 1936 at cost of \$700. Good as new. Mrs. G. F. Smith, 227 E. High Street, Lawrenceburg, Ind. Telephone 26.

**PRACTICE AVAILABLE:** Unopposed general practice in large, wealthy agriculture community. If interested contact Dr. J. F. Smyth, 239 S. Main St., Marion, Ohio, for details on practice, equipment and net income to be expected. Unexcelled opportunity for man without means.

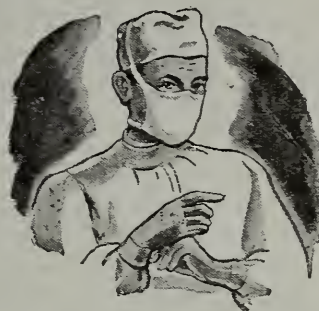
**WANTED:** Laboratory technician, registered or eligible for registration, in small general hospital. Reyburn McClellan, M. D., Xenia, Ohio.

**WANTED:** Physicians for full-time railroad service. Not over 50 years of age. F. N., care of Ohio State Medical Journal.

**FOR SALE:** Beck-Lee electrocardiograph. Looks and operates like new machine. Price \$225.00. R. E. Ramey, M. D., 563 S. Dawson, Columbus 9, Ohio. Telephone: Fairfax 5917.



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# Scientific Study of Health Insurance Problems in U.S. Made By Research Men; Summary of Their Conclusions

**C**OMPULSORY health insurance with all its broad ramifications is reviewed in the July 21 issue of *The Journal of the American Medical Association* which says, editorially, that it "is offered as a report of a scientific investigation into the forces now promoting the mechanism for medical service incorporated in the Wagner-Murray-Dingell bill".

This is an article which all Ohio physicians having access to *The Journal of the A.M.A.* should read. The article, prepared by Carl W. Strow and Gerhard Hirschfeld, Research Consultant and Director, respectively, of the Research Council for Economic Security, sheds light on various national health problems in order that a better view might be obtained on the subject of compulsory health insurance.

In an accompanying editorial, *The Journal of the A.M.A.* said:

"The report by Strow and Hirschfeld is not opposed to organized labor; rather it is offered specifically to organized labor for study so that cooperation may be secured in extending to the worker, to the farmer and to people generally the most that American medicine can give under a democratic system of government. Compulsory sickness insurance leads to regimentation and totalitarianism. The continued evolution of plans for medical care with the acceleration that has been evident in recent years will yield technics for providing medical service adapted to the American way of life."

## NEED FOR DELIBERATION

Strow and Hirschfeld emphasize in the article the need for careful deliberation, both by the government and various states, with regard to current or contemplated proposals for compulsory health insurance.

Pointing to the lack of factual comprehensive information, the researchers said:

"In view of the absence of specific data as to the exact need for medical care, any legislative proposal could hardly be based on anything more substantial than general ideas obtained from over-all estimates. As a result, benefits are not determined on local requirements. The exact cost is not known. The rate of taxation cannot be fixed with any degree of accuracy. A reliable and complete survey of the health problem of the states and of the nation has never been made. Until it is made, and until more information is available, not only as to the cost of compulsory systems but of the effect on such widely divergent factors as government, taxes, enterprise and human nature, care should be taken by the citizen and his legal represen-

tatives to weigh carefully the pros and cons before they decide what they want in the way of health insurance for themselves, for their children, for their state and for their nation."

## ISSUE IN MANY STATES

The authors state that during the legislative sessions of 1945, more than 30 measures proposing cash sickness benefit plans or compulsory health insurance systems were introduced in 12 state legislatures. Other bills called for studies of health insurance, and in Congress a number of bills were introduced providing for some sort of medical care or sickness benefits.

"The demand for compulsory health insurance", the authors said, "has been more consistent and more pronounced in some states than in others. New York, for instance, has had no fewer than 27 health insurance bills introduced in the legislature between 1935 and 1945. Yet New York has far better medical and hospital facilities, as well as provision for social services, than the average state. On the other hand, such states as Mississippi, Georgia, Alabama, Arkansas and the Carolinas, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance."

"Since 1935 and including 1945", the article said, "102 bills have been introduced into the legislatures of 20 states, with success only in Rhode Island, in 1942. The passage of the National Social Security Act in 1935 was largely responsible for the increased activity."

## WHAT DOES PUBLIC THINK?

The two research men said it was difficult to form an exact conclusion on what the public thinks of the problem of health insurance.

"Public opinion polls would indicate that the public favors health insurance", they said, but added cautiously: "However, this depends on the form in which the question is submitted. If it emphasizes benefits, public opinion favors health insurance. But when the question emphasizes the financial cost, the necessary tax burden and the economic consequence in general, the public seems to be less sure about the desirability of a compulsory system."

"Notwithstanding the large amount of voluntary protection against illness, there is no disagreement among the advocates of compulsory health insurance, as well as the opponents, as to the need for better medical care. The disagreement is about the form, the administration, coverage, benefits and many other details. . . .

"The health problem differs in virtually every





## This, too, will be written in history



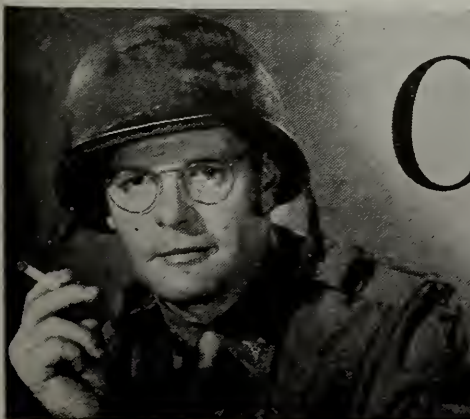
Among the many brilliant originations, the inspired improvisations, of the Medical Corps in World War II was the use of the "ambulance on wings."

When the photograph above was taken, the casualties lined up had *just been wounded!* Already they had been given emergency medical aid, and in a matter of *minutes* were on their way to a base hospital with complete facilities far away from the combat zone . . . Thanks to such immediate surgical care, quick hospitaliza-

tion, and all the companion advancements of wartime medical science, 97 out of every 100 such casualties *lived!*

Thanks should be proffered most generously to the incredible diligence of those "soldiers in white" who created and tirelessly practiced these techniques—the medical men in the service whose rest all too often was no more than a moment and a cigarette. Incidentally, that cigarette was very likely a Camel, an especial favorite of all fighting men.

R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina



**Camels**  
COSTLIER  
TOBACCOS



state. In California, communicable diseases account for a major share of reported illnesses. In Mississippi influenza, syphilis, malaria, gonorrhea and dysentery are high on the list of reported illnesses. In New York cancer, syphilis, tuberculosis and pneumonia are the important health problems.

"This contrast in leading causes of illness makes it difficult to analyze the health problem of our nation and makes it dangerous to generalize on the requirements for better medical care. But there is still another problem . . . the lack of sanitation and hygiene as a major contributing factor to disease."

#### CONCLUSIONS

In conclusion the researchers said:

"The demand for compulsory health insurance is promoted most powerfully by organized collective action, especially by organized labor. . . . Apparently, the opportunity to organize the demand is more important than the prevalence of the need for medical care. The evidence points to the probability that, contrary to popular belief, the legislative proposals for compulsory health insurance are based not so much on social needs as on political interests, and that the ability on the part of labor to organize and press the demand, rather than the concern about the state of health, is the primary consideration. . . .

"Illness apparently is not chiefly responsible for the demand for compulsory health insurance. If it were, recommendations would start in the medically least progressive states. However, they originate at the opposite end of the scale, where medical care and social services are most highly developed."

#### Outstanding Programs Arranged By Cincinnati Academy

The Academy of Medicine of Cincinnati has arranged a splendid scientific program for the year 1945-1946. All interested physicians are cordially invited to attend these meetings, which usually are held in the Academy Auditorium, Sixth Floor, Union Central Annex Building. The program follows:

Oct. 2—M. A. Blankenhorn, M. D., professor of medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, "Persistent Problems of Pneumonia".

Oct. 16—George X. Schwemlein, M. D., co-medical director, Chicago Intensive Treatment Center, Chicago, Illinois, "The Present Status of Penicillin in the Therapy of Syphilis".

Nov. 6—J. W. Conn, M. D., assistant professor of medicine, University of Michigan Medical School, Ann Arbor, Michigan, "Some Problems Related to Insulin Action".

Joint meeting with the Diabetes Council.

Nov. 20—George T. Pack, M. D., assistant pro-

fessor of clinical surgery, Cornell University Medical College, New York, N. Y., "The Extension of Radical Surgery in the Treatment of Cancer".

Joint meeting with the Cancer Control Council.

Dec. 4—Jules Masserman, M. D., assistant professor of psychiatry, University of Chicago School of Medicine, Chicago, Illinois. "Experimental Approach to the Understanding of Neurotic Symptoms".

Dec. 18—Joint Meeting with the Heart Council of Cincinnati. (Speaker to be announced.)

Jan. 8—Bruce Wiseman, M. D., professor of medicine, Ohio State University College of Medicine, Columbus, "The Spleen and Blood Formation".

Jan. 22—H. Houston Merritt, M. D., professor of clinical neurology, Columbia University College of Physicians and Surgeons, New York, N. Y., "The Treatment of Epilepsy".

Feb. 5-6—Milton J. E. Senn, M. D., assistant professor of pediatrics and psychiatry, Cornell University Medical College, New York, N. Y., The B. K. Rachford Lectures.

Feb. 19—E. H. Botterell, M. D., Lieutenant Colonel, R. C. A. M. C., University of Toronto, Toronto, Canada, "Diagnosis and Treatment of Injuries to the Brain and Spinal Cord".

Mar. 5—The Roger Morris Lecture. (Speaker to be announced.)

Mar. 19—Sumner L. Koch, M. D., assistant professor of surgery, Northwestern University Medical School, Chicago, Illinois, "Injuries of the Nerves and Tendons of the Hand".

Apr. 2—Charles A. Janeway, M. D., assistant professor of pediatrics and instructor in bacteriology and immunology, Harvard University Medical School, Boston, Massachusetts, "Studies on Clinical Uses of Plasma Protein Fractions".

Nominating Committees to be elected.

Apr. 16—Harold G. Wolff, M. D., assistant professor of medicine, Cornell University Medical College, New York, N. Y., "Reactions of the Nasal Mucous Membranes and the Stomach Engendered by Emotions".

May 7—Frank H. Lahey, M. D., Lahey Clinic, Boston, Massachusetts, "The Management of Lesions of the Terminal Ileum, Colon and Rectum".

May 21—Walter L. Palmer, M. D., professor of medicine, University of Chicago Medical School, Chicago, Illinois, "The Nature and Treatment of Peptic Ulcers".

Annual Election of Officers.

Logan—Dr. William B. Morrison, Columbus, spoke on "Cancer" at a meeting of the Rotary Club.

Zanesville—Dr. C. F. Sisk has been elected president of the Muskingum County Board of Health.



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Both vaccines available in 6 cc. and 20 cc. vials.

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Since no one clinical test has as yet been devised to differentiate between the several strains which may be involved, the selection of vaccine must depend upon the history of the case. Since most cases are identified with either the bovine or porcine species of organism, it is customary in practice to use a bi-valent vaccine containing these two organisms, except where the caprine organism can be reasonably incriminated.

*Literature on request*

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### PRACTICAL ASSISTANCE FOR RETURNING MEDICS

Acceleration in the return of physicians from the armed forces is anticipated during the next several months. For that reason, local medical societies should be prepared to offer practical assistance to returning medical officers.

Two local medical societies have put ideas into effect which we are referring to here as suggestions of what can be done in all communities where facilities permit.

The Summit County Medical Society is considering the insertion in Akron newspapers periodically of an advertisement informing the public that a certain physician (or physicians) has returned from military duty and has opened an office at such and such address; and that he is an active member in good standing of the Summit County Medical Society.

The idea is a good one, relieving the returning physician of any criticism of self-promotion and at the same time adding the prestige of the county medical society.

The Columbus Academy of Medicine has a very active committee, headed by Dr. C. C. Sherburne, at work on these matters. It has adopted the following nine-point program:

- (1) Arrange through the Medical Bureau for the assignment of a temporary telephone number, which will be listed at the Bureau address and will be answered by that office so that those expecting discharge within the next few months may have their names carried in the next telephone directory.
- (2) Contact real estate board and rental agencies to request the filing with the Academy office of information regarding available office locations; also, to request the special co-operation of these groups to assist returning physicians to secure adequate office space.
- (3) Secure information about the opportunity to enter practice as assistants or associates with doctors now engaged in local practice.
- (4) Secure information about openings for returning physicians on either part or full time basis, in the various local state institutions.
- (5) List the names of all returned doctors periodically in the *Academy Bulletin*, so that their names will be known to all other physicians in order that former patients may be immediately referred back to these war service members.
- (6) Arrange for newspaper announcements, under official Academy sponsorship, regarding the return to practice of war service physicians.
- (7) List at the Academy office the openings for residencies in local hospitals.
- (8) Provide information regarding postgraduate instruction and refresher courses.
- (9) Arrange through the Academy office for financial assistance to those wishing to take advantage of the loan provisions of the Academy Veteran's War Bond Pool.

Here are some good hunches, most of which are feasible in most any area even though it may not have a full-time office as the office of the President or Secretary could be utilized as a clearing house.

Local societies owe much to the men who have served in the armed forces and they should be ready to render practical assistance to them upon their return to civilian life.

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### THEY FINISHED THEIR JOB—LET'S FINISH OURS

"They finished their job—let's finish ours!"

That's the slogan of the Victory Loan Drive which will open on October 29. The overall quota of this Victory government financing campaign is eleven billions—the quota for individuals being four billions.

Some will ask: Why buy bonds now—the war is over?

Here are some of the very good reasons:

To help in the financing of medical care, rehabilitation, education, and other benefits relating to war veterans.

To pay for war materials which were ordered, produced and delivered but not paid for as yet and to finance cancellation and termination of war contracts.

To enable those still drawing big wages to make a sound savings investment and provide a backlog of buying power to be used when consumer goods are available.

To finance the return of veterans from overseas.

To maintain our armies of occupation.

Physicians have been big buyers of war bonds. They should continue this good work by investing in Victory Bonds.

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### LOCAL MEDICAL SOCIETIES FACE REAL TASK AT ONCE

"Medical Societies Face Task", headlines the News Letter of the Council on Medical Service and Public Relations of the American Medical Association, commenting as follows:

"Faced with problems increasing daily, almost hourly in number and importance, the Council on Medical Service and Public Relations appeals to each and every county medical society to do everything possible to hold regular meetings



and maintain an active organization during the coming year.

"It is hoped that those county societies which have discontinued regular meetings during the war will return now to their regular prewar schedule.

"This will be doubly difficult in many cases, due to the fact that individual physicians are so busy and so pressed for time. Despite the working hours faced by every physician in his private practice each must sacrifice a substantial part of his time and effort for medical organization work if the medical profession is to continue to lead in giving the American public the high standard of medical care in the future as in the past."

There are quite a number of County Medical Societies in Ohio who should heed this advice. Getting back to normal as soon as possible should be their chief objective. Members of The Council of the State Association are ready to assist them in every possible way; also the State Headquarters Office, Columbus. Have your Councilor visit your society in the near future. Speakers can be secured without too much difficulty. There's plenty to discuss and plenty of things to do.

#### PRESIDENT TRUMAN'S MESSAGE TO THE CONGRESS

Did you read President Truman's message to Congress on September 6? If not, dig up a copy and digest it. He referred to a good many matters affecting public health and of vital concern to the medical profession.

In concluding his message, the President said:

"I shall shortly recommend a national health program to provide adequate medical care for all Americans and to protect them from financial loss and hardships resulting from illness and accident. I shall also communicate with the Congress with respect to expanding our social security system and improving our program of education for our citizens."

That Mr. Truman did not include a specific recommendation regarding a health program in his 21-point message may or may not be of any great significance.

Is the question such a hot one that the administration is not ready to reveal its views on the matter at this time?

Does the administration feel that the question is of such importance that it deserves a special message?

Does the administration have a program in the making which differs from the Wagner-Murray-Dingell Bill or will that measure receive its endorsement at a later date?

The answers to these pertinent questions are not available to the public at this time.

Nevertheless, the President's statement on this particular matter and those sections of his 21-point message which have a direct bearing

on health and medical activities are sufficient to warn the medical profession that it must keep its powder dry during the ensuing months. The time may just be around the corner when physicians as individuals and as a group will have to assert themselves vigorously to their congressmen on proposed legislation. That means you—not some other doctor.

#### RETURN THAT QUESTIONNAIRE!

EACH of the 108,000 civilian physicians in the country has received a letter and a questionnaire from the A. M. A. Bureau of Information. It is most important that each individual doctor complete and return this questionnaire in order to bring current records at the A. M. A. Headquarters up to date and in order to obtain actual facts in regard to the true distribution of medical care.

#### HOW ABOUT RADIO PROGRAMS IN YOUR COUNTY?

County medical societies who are thinking in terms of public relations (certainly all societies should be thinking in such terms) should not overlook the opportunities afforded by radio broadcasting.

This is the advice of Dr. W. W. Bauer, director of the Bureau of Health Education of the A. M. A., who calls attention to the fact that the Bureau has electrical transcriptions which will be made available to local medical societies for local broadcasts with only nominal charges for shipping.

Where there are local facilities for broadcasts, local medical societies should seriously consider sponsoring programs, using the material from the A.M.A.

#### REAL IMPROVEMENTS IN V. A. ARE IN THE MAKING

Pleas of many groups, including the medical profession, for definite reforms in the Veterans Administration are beginning to bear fruit.

The new administrator, General Omar N. Bradley, has announced the first steps in a reorganization plan, one feature of which is the decentralization of the activities of the agency to eliminate red tape and to provide closer supervision of all facilities. Even though the revised program is still in the on-paper stage, it indicates that real improvements are in the making.

Here are some of the changes which General Bradley has in mind:

Establishment of 13 branch offices (Cincinnati suggested as one) to have direct control and su-

pervision of all veterans' projects in their respective areas.

Decentralization of the administration of insurance and death claims, giving branch offices greater jurisdiction.

Location of veterans' hospitals near medical schools and correlate their activities with those of the medical schools to overcome the shortage of medical personnel and give the veterans the benefit of services and advice of members of the medical faculties.

Establishment of approved internships and residencies in veterans' hospitals.

Give the medical and vocational divisions of the administration equal rank with other departments.

There are indications also that General Bradley and his medical chief, General Hawley, are giving serious consideration to still further decentralization which would make wide use of the services and facilities of physicians in private practice in the care of disabled veterans. This would be a real improvement and they should be encouraged to carry out their ideas along these lines if at all feasible. By the same token, physicians in private practice must be ready to assume any such responsibilities—and do a real job—if and when they are called upon to do so.

#### CHURCH EDITOR SAYS WAGNER BILL THE WRONG APPROACH

In a recent issue of *The United Presbyterian*, official magazine of the United Presbyterian Church, Rev. S. E. Irvine, one of the contributing editors, voices his support of the constructive program of the A. M. A. on the matter of extending to all people the best possible medical care and takes some healthy punches at the Wagner-Murray-Dingell Bill.

Because it is important that physicians when discussing this question with laymen be in a position to quote the views of other laymen, we are reprinting as follows, Dr. Irvine's very timely and pertinent observations:

"The American Medical Association has recently issued a program for 'extending to all people in all communities the best possible medical care'. This is in answer to various schemes which seek to put the administration of medical care in the hands of the government. The latest one is the Murray-Wagner-Dingell Bill which is now in the hands of a Senate committee. The bill provides for a form of compulsory sickness insurance to be paid for by a tax levied upon the individual citizen and his employer. It virtually puts doctors and medical schools under governmental control.

"The program which the A.M.A. offers lists in part the following objectives: Sustained production leading to better living conditions with improved housing, nutrition and sanitation; an extended program of disease prevention, with extension of public health service so that every part of our country will have such service; ex-

tension to all localities of voluntary sickness insurance plans; and provision of hospitalization and medical care to the indigent by local authorities under voluntary insurance plan.

"The prevention of disease and adequate and available medical care are objectives in which all people are interested and concerned. The question is whether they can best be attained through government control or under some such plan as that proposed by the doctors.

"We sympathize with the medical profession in its aversion to state control. It would not only be galling to the practitioner's spirit but interfere seriously with his initiative. Human nature being what it is, men who are on their own are inclined to put more into their work than do those who are employees. The physician whose practice depends upon his competence and attention has a spur to improvement which the salaried doctor does not have. Under the present system the progress of the medical profession has been outstanding. It would be serious to take chances with future medical progress by making our medical men creatures of the state.

"The plan of the American Medical Association offers to achieve the same ends as the Murray-Wagner-Dingell Bill without the obnoxious features of bureaucracy and regimentation. It goes to the root of the matter when it points out that the whole problem rests upon the improvement of economic conditions. If this occurs people will be in position either individually or through insurance plans to provide themselves with hospitalization and medical care. If a serious depression occurs the government plan would fail for lack of revenue.

"The voluntary insurance plan has worked where it has been tried and it could, without much effort, be extended and made general. The proper place of Federal and state governments is in aiding the doctors in medical research, promotion of the public health and preventive medicine and in the care of the indigent. State medicine is no more in harmony with our democratic principles than a state church.—S.E.I."

#### HITLER CONTROLLED THROUGH "GUARANTEED SECURITY"

The *Chicago Daily News*, in a recent edition, published the following interesting comment with respect to the consequences of more than 60 years of social security in Germany:

"Dorothy Thompson, writing from Munich, declared, 'If I had anything to say about German re-education, I think I would begin by permanently abolishing all these pensions'.

"To the German social security system she attributes 'the almost total lack of personal initiative and sense of responsibility, either for the past or the future'.

"The ideal of the German middle class is to fit one's self for some technical or administrative function, says she, then find a nice place to work in until retirement on a pension.

"Hitler, she finds, was able to rule Germany with outward efficiency because the country was administered by officials willing to work for any regime that guaranteed their security.

"Well, Bismarck planned it that way, didn't



## Looking Ahead

*A Message from Thomas L. Luzier, President and Founder of Luzier's, Incorporated*

IN the years ahead industry must meet demands as crucial and urgent as any it faced during the war: it must expand to provide millions of people with the means of self-support.

We must more than maintain our standard of living; we must improve it so that the good things of this life are enjoyed by an ever-increasing number of people who have the will to attain them.

It is estimated that the total cosmetic sales for 1945 will be close to \$600,000,000; and it is generally felt by persons in the industry who are in close touch with its trends that this figure, large as it may seem, will probably be doubled within the next few years.

We look ahead with confidence to a steady expansion of our service, to provide many times our present number of patrons with fine cosmetics and perfumes selected to suit their individual requirements and preferences, and to provide an opportunity for many times our present number of distributors to build a worthwhile business of their own.

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he? And Ferdinand La Salle, Socialist rival of Karl Marx, sold the idea to him, did he not?

"Dorothy Thompson is a good reporter.

"The facts as she reports them, however, are not very good sales arguments for pending legislation in Congress to enlarge vastly the scope of social security laws.

"We like to talk of the 'American Way of Life'. But it is well to remember that the 'American Way' is not the effect of any racial peculiarity of Americans. It is not the result of any special quality of 'blood and soil' to quote the Nazi jargon about the 'master race'.

"The American way is the effect of a specially strong habit of self-reliance acquired in the settlement of a new land. That habit has been handed down and also communicated to new arrivals in the country.

"Should the habit disappear, so will the 'American Way'."

### RADIOLOGISTS WARNED OF BUGS IN NEW WAGNER BILL

The 1945 version of the Wagner-Murray-Dingell Bill contains provisions of enormous interest to radiologists, the *Monthly News Letter* of the American College of Radiology observes. It is intimated that the radiologists are in grave danger under the terms of the proposal. In our opinion, the radiologists are not the only specialists who should be fearful of the outcome if the Wagner Bill should be enacted. All specialists will find themselves in the grease, along with the G.P. and the public generally.

Here are some of the bugs in the new Wagner Bill as noted by the American College of Radiology:

"The 1943 version of Senator Wagner's Bill to socialize medicine apparently contemplated that diagnostic or therapeutic services rendered by specialists in radiology would be paid for under Section 915, either as 'special medical benefits' or as 'laboratory benefits'. In any case, the bill provided for separate payments for roentgen diagnosis or treatment furnished in office or hospital.

"The 1945 version (S. 1050), on the contrary, adopts the view of some of the self-appointed 'medical economists' who have obviously been advising Senator Wagner. These individuals and their views are well known. Among other things, most of them advocate the institutionalization of medicine in or by hospitals or 'health centers'. Their handiwork can be seen in Section 214 (h), which authorized the Surgeon General to contract with hospitals for complete medical care, as provided in Sections 203 and 205.

"Section 214 (g) of S. 1050 defines 'laboratory benefits' as including 'diagnostic and therapeutic X-ray' and further provides 'That when any such services . . . are provided to a hospitalized patient, or are provided by a physician or dentist incidental to services furnished under subsections (b), (c), (d), and (e) of this section, payment for such services . . . shall be included in payments for hospitalization or for services furnished under such subsections, respectively, as otherwise provided in this part'.

"The definition of 'special medical benefits' in Section 214 (c) refers to 'necessary services requiring special skill or experience'. One would think this would include the services of medical specialists in radiology. However, paragraph (g) of the same section contains language indicating that a radiologist is not to be regarded as a 'specialist or consultant', as defined in Section 205 (c).

"The apparent contemplation of the bill is that the cost of roentgen diagnosis or radiation therapy rendered a hospitalized beneficiary must be absorbed by the hospital from the three to seven dollars per diem it receives for hospital care.

"In the case of an ambulatory patient, a general practitioner who went to the expense of making X-ray studies in his own office would receive no extra compensation. If the patient is referred to an internist, surgeon, orthopedist, urologist, or other 'designated specialist', under the provisions of Section 205 (d) and (h), such consultants would not be entitled to extra payment for X-ray studies they might resort to, regardless of how extensive or expensive they might be.

"If, on the other hand, the general or specialist practitioner referred the patient to a radiologist for roentgen diagnosis of treatment, it may be presumed that an additional fee would be paid for his services.

"While this might discourage roentgen examinations by non-specialists, who would receive no additional pay for such procedures, and who would thus be encouraged to refer their ambulatory patients to the offices of specialists in radiology for consultation, the net effect upon the general practice of medicine would undoubtedly be bad.

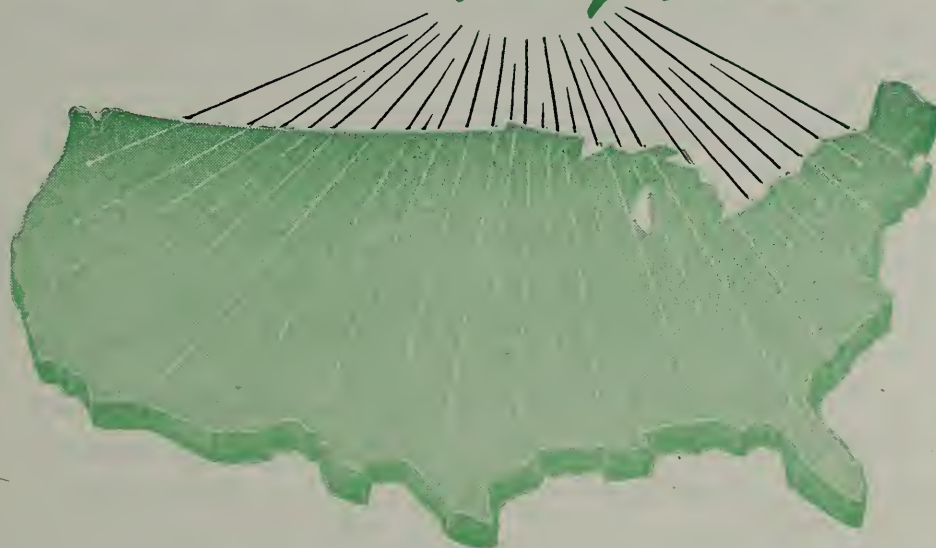
"Too, in view of the fact that more than one hundred million citizens would be entitled to free hospitalization under the act, the bulk of radiological practice eventually would be carried on in hospitals. For this work no extra benefits would be payable. The obvious tendency would be for hospitals to employ a radiologist on as low a salary as possible and reduce by every means the net cost of radiology. No extraordinary perspicacity is required to see that the ultimate effect upon the quality of radiological service and the future of the specialty would be deplorably bad."

### Condemned Slayer's Eyes Removed And Sent To Eye Bank

Elder Johnson, a 53-year-old Columbus man, electrocuted at the Ohio Penitentiary September 8, for the murder of a night watchman, offered to donate his eyes "for the good of blind humanity". Within a few minutes after he was pronounced dead, Dr. A. D. Frost, professor of ophthalmology at Ohio State University College of Medicine, removed the slayer's eyes, placed them in a special container and dispatched them by air mail to the Institute of Ophthalmology, Presbyterian Hospital Unit, at Columbia University, New York. There they will go into the eye bank conducted by Dr. Ramon Castroviejo, a pioneer in the delicate operation which restores sight to a blind person with a corneal defect through the grafting of healthy corneal tissue.



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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### CLINTON

The regular meeting of the Clinton County Medical Society, Sept. 4, at the General Denver Hotel, Wilmington, was well attended. Dr. V. E. Hutchens gave a very interesting talk on "Care of the Aged". A general discussion followed.—R. W. DeCrow, M.D., secretary.

### HAMILTON

Dr. William J. Graf gave the address of the retiring president and Dr. David A. Tucker, Jr., the inaugural address of the incoming president at the first regular meeting of the 1945-1946 year of the Cincinnati Academy of Medicine, Sept. 18.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### MIAMI

"Neuropsychiatric Problems of Returning Service Men", was the subject of an address made by Dr. George T. Harding, Columbus, at a meeting of the Miami County Medical Society, Sept. 7, at the Piqua Memorial Hospital.—G. A. Woodhouse, M.D., secretary.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### MARION

The Marion County Academy of Medicine endorsed the Jobs and Progress Program of the local Civic Planning Group and approved a donation of \$25 to the cause, at a meeting Sept. 4, at the Marion City Hospital. Dr. Louis N. Jentgen, Columbus, spoke on "Treatment of Coronary Disease".—News clipping.

## Fourth District

(COUNCIL: A. A. BRINDLEY, M. D., TOLEDO)

### PUTNAM

Dr. H. A. Neiswander was host to members of the Putnam County Medical Society, and their wives, at a dinner meeting, Sept. 4, at Witteborg's Cafe, Columbus Grove. Dr. W. C. Lacock, Beaverdam, outlined training of medical corpsmen and the functioning of the Army unit in which he served overseas.—News clipping.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

Dr. Roger E. Heering, State Director of Health, discussed "Medicine in Public Health", at a meet-

ing of the Mahoning County Medical Society, Sept. 18, at the Youngstown Club, Youngstown.—Bulletin.

### PORTAGE

Capt. James Beal and Capt. Harris S. Wendorf, former Ravenna physicians, were the speakers at a meeting of the Portage County Medical Society, Sept. 4, at the Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

### SUMMIT

"Allergy in the General Practice of Medicine", was the subject of an address made by Dr. Jonathan Forman, Columbus, at a meeting of the Summit County Medical Society, Sept. 11, at the Akron City Hospital.—Bulletin.

## Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

### MUSKINGUM

Darrell Adams, of the local Veterans Administration office, was the speaker at a meeting of the Muskingum County Academy of Medicine, Sept. 5, at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secretary.

### PERRY

A hospital for Perry County was proposed at a meeting of the Perry County Medical Society, Aug. 30, at the Park Hotel, New Lexington. Guests included the county commissioners and other officials.—News clipping.

## Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M. D., PORTSMOUTH)

### SCIOTO

At the regular monthly meeting of the Hempstead Academy of Medicine, Sept. 10, in the Nurses' Home, Portsmouth General Hospital, members enjoyed colored films on "Diagnosis and Surgical Treatment of Breast Cancer."—Thomas W. Frame, M.D., secretary.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)

### LORAIN

Dr. John W. Holloway, assistant clinical professor of surgery, Western Reserve University School of Medicine, Cleveland, spoke on "Regional Ileitis", at a meeting of the Lorain County Medical Society, Sept. 11, at The Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

Columbus—Dr. Arthur B. McConagha, has been re-elected to a five-year term on the Franklin County Board of Health.



# SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

**V**ITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park\* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

\*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, *Am. J. Dis. Child.* 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

MEAD'S Oleum Percomorphum furnishes 60,000 vitamin A units and 8,500 vitamin D units per gram. Supplied in 10- and 50-cc. bottles; also available in bottles of 50 and 250 capsules. Ethically marketed.

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# In Memoriam

Joseph Bruce Alexander, M. D., Mansfield; Eclectic Medical College, Cincinnati, 1918; aged 57; died Aug. 22. Dr. Alexander formerly practiced at Cheviot. His widow, two daughters and two brothers survive.

William David Davis, M. D., East Canton; Lincoln Memorial University Medical Department, Knoxville, Tenn., 1893; aged 77; member of the Ohio State Medical Association and the American Medical Association; died Aug. 22. Dr. Davis retired in 1941, after practicing in Stark County for 48 years. He was president of the township Board of Education for 25 years. Dr. Davis was a member of the Methodist Church, the Masonic Order and the Knights of Pythias. Surviving are his widow, three daughters, two sons and a sister.

Irving A. Nelson, M. D., Canton; Western Reserve University School of Medicine, Cleveland, 1891; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died Aug. 24. Dr. Nelson retired several years ago, after having practiced in Smithville and Canton for many years. He was a member of the Christian Church. His widow and a daughter survive.

Gustav Adolph Mack, M. D., Gallipolis; Bellevue Hospital Medical College, New York, 1894; aged 77; member of the Ohio State Medical Association and the American Medical Association; died Aug. 18. Dr. Mack, dean of the medical profession in Gallipolis, practiced there for nearly 50 years. He was a former coroner of Gallia County and had served as physician for various fraternal orders and county institutions. Dr. Mack was a member of the Methodist Church, the Knights of Pythias, Woodmen of the World and the Modern Woodmen of America. His widow and a sister survive.

James McClymonds McGeorge, M. D., Salem; University of Wooster Medical Department, Cleveland, 1902; aged 70; former member of the Ohio State Medical Association, American Medical Association and the American College of Surgeons; died Sept. 1. Dr. McGeorge retired three years ago after having practiced in Salem for 35 years. He was formerly chief of staff at the City Hospital, and served with the Medical Corps of the U. S. Army during World War I. Dr. McGeorge was a member of the Presbyterian Church and the American Legion. Survivors include his widow and a sister.

Edward O. Morrow, M. D., Canton; Starling Medical College, Columbus, 1887; aged 80; member of the Ohio State Medical Association and

## DIED WHILE IN MILITARY SERVICE

Arch Lavere Oldaker, M.D., Cleveland; Western Reserve University School of Medicine, 1929; aged 45; member of the Ohio State Medical Association and the American Medical Association; died May 8, 1942, of malaria in the Philippines, according to a recent announcement of the War Department. After internships at Charity and Lakewood hospitals, Dr. Oldaker practiced in Cleveland until October, 1940, when he entered military service as a captain in the Medical Corps. Originally assigned to the 145th Infantry, 37th Division, he was sent to the Philippines late in 1941. After the fall of Bataan, Capt. Oldaker joined a guerilla outfit and subsequently developed the disease which caused his death. He is survived by his widow, a son, his father and a sister.

Howard D. Adams, M. D., Galion; George Washington University School of Medicine, Washington, D. C., 1944; aged 27; died Aug. 22, after an illness of two days, at the Regional Hospital, Ft. George G. Meade, Md. A first lieutenant in the Medical Corps of the Army of the United States, Dr. Adams reported for duty July 8, 1945, upon completion of his internship at Genessee Hospital, Rochester, N. Y. Surviving are his parents, Dr. and Mrs. Clarence A. Adams, Galion; his widow and a son, a brother and a sister.

the American Medical Association; died Aug. 26. Dean of the medical profession in Canton, Dr. Morrow retired a year ago after 56 years in practice there. A member of the staffs of both Mercy and Aultman hospitals, he laid the cornerstone in the Winter of 1943 for the new wing to Aultman Hospital, as the only surviving physician who had served on the first staff. When Dr. Morrow completed 50 years in the practice of medicine in 1937, he was honored by the Canton Medical Library Association, of which he was one of the founders. He was a member of the Lutheran Church and the Masonic Order. A brother survives.

Harold Waldron Seff, M. D., Delaware; General Medical College, Chicago, 1924; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died Aug. 21. Dr. Seff had been city-county health commissioner at Delaware since May, 1944. He



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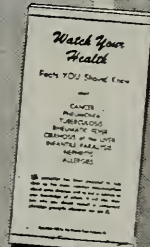
• **CANCER** killed 163,000 people in the United States during 1942, it is estimated\*, and ranks second in causes of deaths. The rate apparently is increasing. About 300,000 new cases are diagnosed for the first time each year and approximately 475,000 persons are under treatment at any given time.

Many cancer patients can be cured by surgery, X-ray or radium if the disease is diagnosed early enough. There is not, however, sufficient information about the cause of cancer and its characteristics to have led to the discovery of a specific and generally applicable cure. Physicians are helping by reporting their experiences and observations. What will be the cure? Who will discover it?

People should be educated to the necessity of having examinations at the first symptoms indicative of cancer so that such curative measures as are available may be utilized as quickly as possible. Too many hide their condition until a cure is impossible.

To aid in such educational work, we have prepared a pamphlet — "Watch Your Health" — in which simple facts about this and six other serious diseases are given. Copies for distribution to your patients are available on request.

\*U. S. Summary of Vital Statistics, 1942



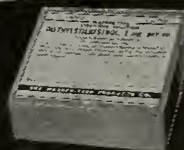
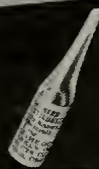
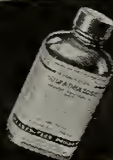
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was with the Chicago Health Department for two years and in 1929 and 1930 was in public health work in Cleveland. He was later associated with the State Department of Health. Surviving are his widow and a son.

**Henry Wilbur Sager, M.D.,** Marion; National Normal University College of Medicine, Lebanon, 1892; aged 81; died Aug. 27. Dr. Sager practiced in Marion for many years. His widow, a sister and two brothers survive.

**Robert Sidney Sloan, M.D.,** Columbus; Ohio State University College of Medicine, 1921; aged 49; died Aug. 30. Dr. Sloan practiced in Columbus for over 20 years, and was a former assistant physician at the Ohio Penitentiary. His parents and a sister survive.

**Charles Gregory Smith, M.D.,** Cincinnati; Eclectic Medical College, Cincinnati, 1890; aged 76; died Sept. 3. Dr. Smith practiced in Cincinnati for 55 years, and taught chemistry at Eclectic Medical College. He was a member of the Baptist Church and the Masonic Order. Surviving are his widow and a son.

**Friend Wilford Trader, M.D.,** Columbiana; University of Pittsburgh School of Medicine, 1923; aged 46; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Aug. 30. An active practitioner in Columbiana County for 20 years, Dr. Trader was on the staff of the Salem Hospital, and was president of the Columbiana Board of Education. He was a member of the Methodist Church. His widow, a daughter and a son survive.

**Carl Watson, M.D.,** Findlay; Cleveland-Pulte Medical College, 1901; aged 68; died Aug. 17. Dr. Watson retired from medical practice in 1908, after having practiced in Toledo for seven years. During World War I he was a captain in the Medical Corps of the U. S. Army, and after the war devoted his entire time to his farming and oil interests. Active in Democratic politics for 25 years, Dr. Watson had been chairman of the Hancock County Executive Committee, and in 1933-34 he was state chairman. He was appointed Ohio administrator for W.P.A. in 1933 and continued in that position until W.P.A. was abandoned about four years ago. Dr. Watson was a member of the Masonic Order. His widow and a sister survive.

**Charles Luther Wood, M.D.,** Lakewood; University of Wooster, Medical Department, 1898; aged 74; died July 19. Dr. Wood practiced in Lakewood for 46 years. He was a member of the staff of Lakewood Hospital. Dr. Wood was a Mason. His widow and a son survive.

**William Lewis Yeomans, M.D.,** Bucyrus; University of Toronto Faculty of Medicine, 1897; aged 71; member of the Ohio State Medical Association and the American Medical Association; died Aug. 30. Dr. Yeomans practiced in Bucyrus for 46 years. He had been legislative committee-man and delegate of the Crawford County Medical Society. Dr. Yeomans was a member of the Masonic Order and the Elks Lodge. Survivors include his widow, two daughters, a brother and a sister.

**Albert A. Yungblut, M.D.,** Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 73; member of the Ohio State Medical Association and the American Medical Association; died Aug. 21. Beginning the practice of medicine in the office of the late Dr. Christian R. Holmes, Dr. Yungblut practiced in Cincinnati for 42 years. He is survived by his widow and two sisters.

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### Psychiatric Clinic Will Be Opened At Western Reserve Medical Center

A program to establish a psychiatric clinic at University Hospitals, Western Reserve University, to provide treatment for civilians at a nominal fee and free treatment for service men and their families who are referred there by the American Red Cross, has been approved by the boards of trustees of the university and of the hospitals.

Establishment of the clinic is made possible through the Greater Cleveland Red Cross chapter, which has procured financial support for the part of the program applying to service men and their families. It is anticipated that some support for the civilian part of the program will be sought later through a public campaign.

The clinic will be staffed by five psychiatrists, one psychologist, and psychiatric social workers and nurses. It will be housed temporarily in Lakeside Hospital and eventually in a new psychiatric building, to cost approximately \$450,000 and to adjoin the other hospitals of the university group on Western Reserve campus. Maj. Douglas D. Bond, head of psychiatry in the U. S. Air Surgeon's office, will direct the clinic and will head the new department of psychiatry at Western Reserve University.

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**Warren**—Dr. A. J. Love is general chairman of the local Urban League membership campaign.

**Dayton**—Dr. John L. Carter retired recently after 50 years in the practice of medicine.

**Sidney**—Dr. A. B. Gudenkauf, local physician for 40 years, retired on June 1.

**Columbus**—Dr. M. T. Dixon, now in his 59th year as an active practicing physician, has been in his present office for 50 years, and for 54 years in the same block.



## POWERFUL TO DECONGEST



*Powerless to Re-congest...* In the symptomatic treatment of common colds and sinusitis, Neo-Synephrine is noteworthy for its long-lasting decongestive action which promotes breathing comfort and facilitates sinus drainage. Noteworthy also is its marked freedom from compensatory re-congestion and systemic side effects.

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ciliary activity; isotonic to avoid irritation.

**INDICATED** for symptomatic relief in common cold, sinusitis, and nasal manifestations of allergy.

**SUPPLIED** in ¼ % and 1 % solutions, bottles of 1 fl. oz.; ½ % jelly in col-

lapsible tube with applicator.

**ADMINISTRATION** may be by dropper, spray, or tampon, using the ¼ % solution in most cases and the 1 % when a stronger solution is indicated. The ½ % jelly in tubes is convenient for patients to carry.

FURTHER FACTS FOR YOUR REFERENCE FILE WILL BE GLADLY SENT ON REQUEST

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# Red Cross Adopts Policies and Procedures for Chapter Participation in Civilian Blood and Plasma Programs

**P**OLICIES, principles and procedures governing the participation of American Red Cross Chapters in local programs to provide blood and plasma banks for civilian use have been announced by national officials of the Red Cross.

Medical and health agencies in Ohio which now have or are planning a program to furnish blood and blood derivatives for civilian use and are interested in obtaining the assistance of Red Cross chapters should contact their chapter if the territory the program is to serve is within an individual chapter's jurisdiction, or the appropriate area office of the American National Red Cross if the program is to serve a territory involving the jurisdiction of more than one chapter.

## CONDITIONS TO BE MET

Chapters of the American Red Cross desiring to do so may participate in civilian blood donor services only on the receipt of authorization from the area manager. Such authorization may be granted only when the following conditions are met:

(a) That the responsibility for technical operations, staff and equipment rests with a reliable medical or health agency.

(b) That participation of the chapter is limited to the recruitment or enrolment or both of volunteer donors and the provision of nontechnical staff and equipment.

(c) That the community is not serving as a source of blood for the Army and the Navy or, if it is, that the amount of blood required for civilian needs is obtainable over and above the needs of the armed forces.

(d) That participation of the chapter is limited to one program of volunteer blood donor service for civilians in any one community. If two or more medical or health agencies wish to sponsor programs in the same locality with Red Cross participation, a joint arrangement shall be developed.

(e) That the sponsoring medical or health agency meets the minimum technical standards specified by the American National Red Cross. These will be prescribed in conformity with all applicable government requirements, by a national advisory committee of specialists in the field of blood transfusion and blood substitutes to be appointed by the chairman of the American National Red Cross.

(f) That the service as set up in each individual case is officially approved by the health department having jurisdiction, the appropriate medical society and the hospital agency.

(g) That the service is designed to serve all acceptable hospitals and clinics and all physicians licensed to practice medicine and surgery in the communities where the service is conducted.

(h) That no charge is to be made physicians, hospitals, clinics or patients for the blood or blood derivatives produced under the program. In other words, the costs of donor recruitment,

donor center operation, the collection and transportation of blood, the processing of plasma and other by-products, and the distribution of whole blood and its derivatives must be met by other means than a charge to physicians, hospitals, clinics or patients for any of the products furnished for use.

(i) That the care and protection of donors is to be wholly the responsibility of the sponsoring medical or health agency.

(j) That the sponsoring medical or health agency agrees that the cooperating chapter or chapters will be the sole donor recruitment and enrolment agency for the program. This will avoid the confusion of the public and the consequent loss of effectiveness of appeal that would ensue if responsibility should be shared with other agencies in the community. However, it should be understood that cooperative relationships may be established with local agencies which are interested in assisting the chapter by recruiting donors from their personnel or their constituencies.

(k) That blood donors are to be recruited on a voluntary basis and blood is not to be accepted from any person paid to donate.

(l) That the Red Cross is to be responsible for seeing that there is adequate publicity for donor recruitment, to acquaint the public with the purposes for which its blood is to be used.

(m) That the chapter is in a position to finance its part of the project without financial assistance from the national organization.

(n) That the American National Red Cross is permitted to draw on reserves of blood or blood derivatives as occasion may require for use in disasters or other emergencies.

## ADMINISTRATION OF THE PROGRAM

1. *In Chapters*—An application for authorization to participate in a civilian blood donor service must be submitted by the chapter chairman to the area manager for approval before the chapter may take part in such a project. When authorization from the area manager has been received, the chapter will appoint a Civilian Blood Donor Service Committee to conduct and supervise the chapter program. This committee should include representatives from appropriate chapter services, the medical society, the health department and the hospitals. The chapter committee on Civilian Blood Donor Service will look to the area medical director for advice and guidance in the conduct of the program.

2. *In the Area Offices*—The conduct of the program in the areas is a function of the area medical director. He will maintain liaison with public and private medical and health agencies operating programs to supply blood and blood derivatives and will supervise the civilian blood donor service operations conducted by the chapters.

3. *At National Headquarters*—Under the general supervision of the national medical director,



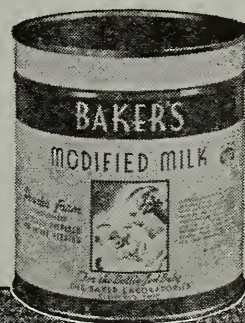
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Baker's Modified Milk is advertised exclusively to the medical profession, with feeding instructions supplied to physicians and hospitals only. Write for full information and samples.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B<sub>1</sub> and D. Not less than 400 units of vitamin D per quart.



# BAKER'S MODIFIED MILK

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the director of Civilian Blood Donor Services will maintain liaison with the national advisory committee of specialists in the field of blood transfusion and blood substitutes. He will prepare the technical standards for the guidance of the sponsoring medical and health agencies in the procurement and processing of human blood, and the necessary basic instructions covering the policies and procedures for the guidance of chapters in the procurement and enrolment of donors. He will give general supervision to the operation of the program and will be available as a technical consultant through the area offices.

#### CHAPTER PARTICIPATION

Authorization will be granted to Red Cross chapters to participate in civilian blood donor services only in case the chapter and the sponsoring agency meet the terms and conditions stipulated by the American National Red Cross. This requirement is in the interest of giving to the civilian population the benefit of the intensive experience gained by the American National Red Cross and the agencies associated with it in the operation of its blood donor service for the armed forces. It will also encourage the establishment, on a nationwide basis, of proper standards of donor procurement and enrolment and of blood procurement and processing. The continuance of the American Red Cross in the field of blood donor service, for which its name and emblem have virtually become the symbol during the war, should inspire public confidence and stimulate a more ready response on the part of volunteer blood donors. This should facilitate the widest possible distribution of the products of blood donor services to those who need them.

#### Discovery of X-Ray To Be Observed

Various professional and lay groups interested in the X-ray will celebrate the 50th anniversary of its discovery at a meeting to be held in the Cleveland Medical Library on Thursday, November 8. In the afternoon there will be talks by a radiologist, a dentist and a research industrialist. In the evening, after a short historical program, there will be an exhibit illustrating the various uses of X-ray in medicine, dentistry, public health and industry. The exhibit will be open to the public on Sunday afternoon, November 11. The committee in charge consists of Dr. Howard Dittrick (chairman), J. T. McCarthy, L. O. Olson, H. J. Wallace, Dr. J. S. Driver, Dr. Otto Glasser, Dr. Harry Hauser and Dr. J. A. Sweeney.

Middletown—The local Boy Scout Commissioners' staff recently adopted a resolution expressing appreciation and gratitude to Dr. W. A. Whitman for his services as a physician at Camp Hook.

### WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

#### BUTLER

Plans for the coming year were discussed at a luncheon meeting of the executive board of the Woman's Auxiliary to the Butler County Medical Society, held at the Manchester Hotel, Middletown, Aug. 31, with the president, Mrs. Fred W. Brosius, presiding. Mrs. Ross Hill, program chairman, announced the names of speakers obtained for the year. The first meeting was to be held on Sept. 26, at the home of Mrs. H. J. Baker, Hamilton, with Capt. William Scott, Columbus, a member of the famous Merrill's Marauders, as the speaker.

#### RICHLAND

Mrs. R. S. Fidler, Columbus, President of the Woman's Auxiliary to the Ohio State Medical Association, outlined the aims and projects of the state organization, at a luncheon meeting of the Woman's Auxiliary to the Richland County Medical Society, Sept. 10, at the Leland Hotel, Mansfield. Mrs. Wilmot Peirce, new president, conducted the business session.

#### ROSS

Thirteen members were present at a meeting of the Woman's Auxiliary to the Ross County Academy of Medicine, Sept. 6, at Allyn's dining room, Chillicothe. Mrs. Loy Hoyt, the president, presided. Mrs. Walter Breth gave a review of the progress of Ohio Medical Indemnity, Inc., the insurance company sponsored by the Ohio State Medical Association. New committees for the coming year were announced and plans were made to order an incubator for the local hospital.

#### SUMMIT

Mrs. Paul A. Davis, Akron, President-Elect of the Woman's Auxiliary to the Ohio State Medical Association, was one of the pourers at a membership tea given by the Woman's Auxiliary to the Summit County Medical Society, Sept. 4, at the home of Mrs. J. G. Blower, Akron. The members were greeted by Mrs. C. F. Wharton, the president, and Mrs. R. F. Thaw, a member of the hospitality committee.

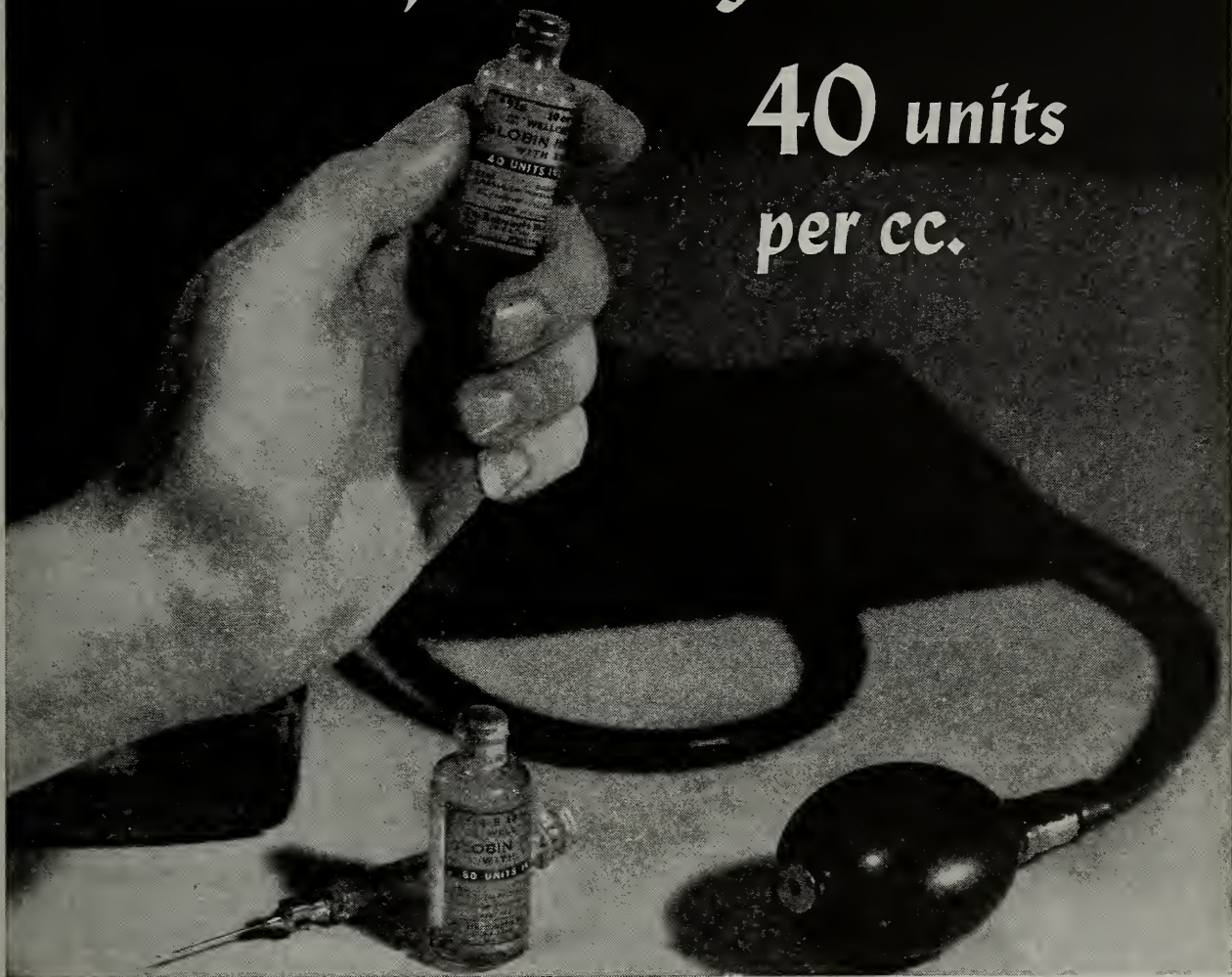
Last year members of the Auxiliary gave over 1,700 volunteer hours to wartime projects. Many members assisted at the Red Cross blood bank. Others worked as volunteers at the Summit County Tuberculosis Clinic and instructed Red Cross home nursing classes. Some members were on duty as receptionists at local hospitals. In addition, the Auxiliary contributes to a fund which provides a scholarship for two student nurses.

Canton—Dr. E. B. King spoke on "Common Disorders of the Nose and Throat" at a meeting of the Massillon Y's Men's Club.



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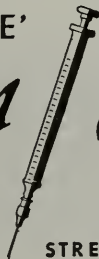


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ished activity at night minimizing the likelihood of nocturnal reactions.

The new 40 unit strength will be readily distinguishable by a distinctive *red* and tan label. As before, the 80 unit per cc. ampule is easily recognized by its *green* and tan label. Both strengths are available in vials of 10 cc. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Literature on request. 'Wellcome' Trademark Registered.

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# WAR NOTES

The first communication to *The Journal* directly from Japan came from Capt. J. H. Geyer, Columbus, now in Yokohama with the 221st A/B Company of the 11th Airborne Division. He writes: "We flew from Southern Luzon to Okinawa and then flew into Japan. We were General MacArthur's honor guard—first troops into the Land of the Rising Sun. Incidentally, we haven't seen the sun since we have been here, clouds all the time. We are stationed at Yokohama, Jap Naval Base and are releasing P.W. camps and disarming Japs. The whole maneuver is still done with extreme caution and there is absolutely no fraternization with the Jap Army or civilians. We want no incidents—but we are prepared, have no fear . . ." Incidentally, the letter was dated Sept. 8, postmarked Sept. 13, and received, via air mail, Sept. 18.

\* \* \*

First Lieut. David Brown, Columbus, has been freed from a Japanese prison camp, according to information received by his parents. A graduate of Ohio State University College of Medicine in 1935, Dr. Brown went overseas in Aug., 1941, and was taken prisoner after the fall of Bataan. He was last reported in Osaka Camp No. 1.

\* \* \*

Lt. M. D. Shilling, Ashland, medical officer on the U.S.S. *Libra* (AKA 12) went ashore in Yokohama on V-J Day, and saw evidence there "of what they had received in the way of lend-lease via B-29's".

\* \* \*

Information about Miami Countians in the service, from Dr. George A. Woodhouse, secretary of the Miami County Medical Society: Capt. Harry Shilling, Troy, home in the Spring and reassigned in the States . . . Capt. Fred B. Hapke, Troy, in Burma, according to last reports . . . Capt. Howard Farmer, Fletcher, had both legs broken while evacuating troops in France. Home on 30-day leave, wearing braces on both legs . . . Lt. Col. Kenneth Lowry, Troy, recently promoted, received several decorations, attached to a general hospital in France . . . Capt. Paul E. Foy, Troy, has seen tough service on the initial invasions on Leyte and Okinawa, now in Manila for reassignment . . . Maj. Hugh Wellmeier, Piqua, assigned to a general hospital assembling at Camp Crowder, Mo., when the Japs signed preliminary surrender papers . . . Capt. Emory Irvin, Bradford, in Austria with the Army of Occupation, re-

THE HEADING of this section of The Journal may have been outmoded by V-J Day, but the war is still on, insofar as we are concerned, until all Ohio medical officers are back in civilian practice. This unit is on a "for - the - duration - and - six - months" basis too. Activated in February, 1942, it has only 45 critical points and may be subject to reassignment or redeployment, but it will not be deactivated as long as there are some "War Notes". By the way, how's for an item now and then?

cently telephoned home from Switzerland . . . Maj. Wm. W. Trostel, Piqua, still at the Veterans Facility, Atlanta, Ga. . . Lt. E. R. Torrence, Troy, on Okinawa with the Marines, where he met Capt. Paul E. Foy . . . Capt. John Beachler, Jr., Piqua, urologist for a general hospital on Leyte.

\* \* \*

The proposed reorganization of the War Department is said to include plans to take the Surgeon General's Office, along with the Adjutant General's Office and the Provost Marshal General's Office out of the Army Service Forces and place them directly under the Secretary of War.

\* \* \*

Comdr. Paul O. Huth, Cambridge, is stationed at the Oak Knoll Naval Hospital, Oakland, California. He served two years in the South Pacific.

\* \* \*

Recently promoted to his present rank, Comdr. Sterling W. Obenour, Zanesville, has been on the U.S.S. *Fuller* since Feb., 1945. His previous duty included: U. S. Marine Base, Quantico, Va.; Norfolk Navy Yard; Treasure Island, Calif., and at the first base hospital established in the Marianas Islands after they were recaptured from the Japanese.

\* \* \*

Around the world with Cincinnati medical officers, courtesy of the Cincinnati Journal of Medicine: Lt. Col. Robert H. Kotte, executive officer of the 55th General Hospital in England, recently moved to France, where he awaits further orders. . . Lt. Col. Frank H. Mayfield and Mrs. Mayfield announce the birth of a daughter, Jeanne Victoria, at Battle Creek, where Col. Mayfield is doing neuro-surgery at Percy Jones General Hospital. . . After a year in the Aleutians,



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Lt. Comdr. John G. Fleming has been at the Naval Air Center Hospital, Pensacola, Fla., for the past year, as obstetrician for the wives of Navy personnel. . . . Capt. Joseph B. Filger, on the oto-laryngological service of the 25th General Hospital, at Tongres, about eight miles from Leige, Belgium. . . . Maj. Clyde S. Roof, chief of surgery, Camp Roberts, Calif. . . . Maj. Roy L. Kile, with the U.S. Public Health Service, attached to the City Department of Health, Cleveland. . . . Lt. Arthur H. Spreen, on Guam, living in a tent, but hoping to rate a Quonset hut soon. . . .

Capt. Nathan R. Abrams, McKinley, Texas. . . . Maj. Jackson Wright, previously with the 25th General Hospital, later transferred to the 94th General Hospital, and now in France, awaiting orders. . . . Lt. Comdr. John B. Toepfer, at the U.S. Naval Hospital, Portsmouth, Va., for the past seven months, after two years in the South Pacific. . . . Out at Pearl Harbor is Lt. Comdr. Ogden H. Baumes, who was head of the medical department at San Diego Naval Hospital for 21 months. . . . Capt. Wesley P. Damerow, in Bavaria with the 51st Evacuation Hospital, 7th Army, was in action in North Africa, Italy, Southern France and Germany. . . . Capt. Harold W. Eckel, recently transferred to Florida from Randolph Field, Texas. . . . Maj. Edward A. Gall is doing pathological work at Valley Forge General Hospital, Phoenixville, Pa. . . . Home for a 20-day leave, his first in three years, Lt. Comdr. Richard D. Bryant has traveled to the Philippines, Formosa and the China Sea as medical officer on a tanker.

Maj. Gerson Lowenthal, chief of E.N.T. at Ashburn General Hospital, McKinney, Texas. . . . Lt. Comdr. Symmes F. Oliver, in charge of admitting patients at the U.S. Marine Hospital, Galveston, Texas. . . . Capt. Nathan Shapiro, recently assigned to overseas duty, after two years at Lovell General Hospital, Ft. Devens, Mass. . . . Capt. Ray O. Nulsen, Camp Shanks, N.Y. . . . Capt. Harry K. Hines, in the X-ray department of the 24th Station Hospital, in Assam, India. . . . Out on the Atlantic for two years on a Coast Guard weather patrol boat has been the assignment of Dr. John F. Sanker, U.S.P.H.S. . . . Capt. Daniel C. Rivers, specializing in cardio-vascular diseases at Ft. George Wright, Spokane, Wash. . . . Capt. Lawrence C. Goldberg, Oliver General Hospital, Augusta, Ga. . . . Maj. Clyde Dummer, F.A.T.S.A., Regional Hospital, Patterson Field, Fairfield.

\* \* \*

According to a radio broadcast, Maj. Calvin G. Jackson, Kenton, who was taken prisoner by the Japanese at Manila in 1942, has been released from the Ashio prison camp near Tokyo.

## VETERAN CAN RENEW HIS DRIVER'S LICENSE WITHOUT EXAMINATION

A RECENT RULING by Attorney General Hugh Jenkins enables returning veterans who have previously held driver's licenses to renew such licenses without examination. The privilege heretofore had been restricted by law to those who had been honorably discharged, and in some instances local registrars had refused driver's licenses without examination to service men on terminal leave or inactive status. Attorney General Jenkins' broad interpretation of the law clarifies the situation.

Lt. Comdr. Clair B. King, Canton, is S.M.O. aboard the U.S.S. Fremont, an A.P.A. now undergoing alterations and repairs at San Francisco. He had a 28-day leave back home in "God's Country", after having been at sea since Dec. 1. Dr. King was in on the invasions at Langayen Gulf and Iwo Jima.

\* \* \*

Thirty-three months' duty overseas earned Capt. J. J. Sofranec, Youngstown, a seven-day leave on the Riviera. He is with the 110th Station Hospital, "due for the Army of Occupation in Vienna, Austria".

\* \* \*

Maj. R. O. Ruch, U.S.P.H.S., Lima, has been transferred from Omaha, Nebr., to Corpus Christi, Tex., where he is V.D. officer for the city and two counties, and medical director of Parkview Hospital, a rapid treatment center.

\* \* \*

Via a 17-day cruise on a Liberty ship, Capt. John Repasky, Akron, is back in the states after 20 months in England. Originally with the 348th Station Hospital, he was transferred in April, 1945, to the 83rd General Hospital.

\* \* \*

Jingles from the corner of Broad and High, courtesy of The Bulletin of The Columbus Academy of Medicine: Comdr. H. M. Clodfelter and Lt. Comdr. Bob Smith, happy over recent promotions, and eager to get home. Dr. Clodfelter is on an island in the Pacific. Dr. Smith, after sea duty on a battle-wagon out there, is doing surgery at the U. S. Naval Hospital, Norfolk, Va. . . . Maj. Frank E. Hamilton, chief of the surgical service in a 750-bed station hospital in France. . . . Maj. Lovell W. Rohr, recently assigned to the 281st Army Air Force Base Unit, Second Air Force, Brownsville, Texas. . . . Maj. Carr E. Dix, home on a 30-day leave from Italy. . . . Lt. Col. Claude S. Perry,



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back in practice, after nearly five years in the service. . . . Lt. Col. Gilman D. and Maj. Robert C. Kirk, home on leave from the E.T.O. . . . Lt. Comdr. Warren G. Harding, transferred from the Naval Hospital, Seattle, Wash., to the Naval Hospital, Newport, Rhode Island. . . . Capt. Ervin B. Wallace, transferred from the 26th Field Hospital at Munnheim, Germany, to a unit in France which was scheduled to go to the Orient. . . . Lt. William L. Craver, with the Marines on Okinawa.

\* \* \*

Maj. Robert C. Haubrich, Pataskala, has been decorated with the Bronze Star Medal for his services at Okinawa. A flight surgeon with the 7th Air Force, he accompanied combat airmen on sorties against the Japanese, and studied their reactions and equipment in combat in order to provide for more efficient training and equipment.

\* \* \*

Lt. Col. Arthur G. King, Cincinnati, four years in the service, including 28 months overseas, has reported to Bushnell General Hospital for duty as chief of the obstetrical service. Assigned to the Pacific Theater in January, 1942, Dr. King was initially stationed in New Caledonia, where he was one of the first Army personnel to report for duty on Guadalcanal Island, when he preceded the landing of infantry units to make a sanitary survey. Following this he was surgeon for the service command unit at New Caledonia and later in the New Hebrides. In June, 1944, Dr. King was ordered back to the states and assigned as executive officer of the station hospital at Camp Breckinridge, Ky. He was then assigned in turn to the Regional Hospital at Ft. Knox, Ky., as chief of obstetrics and to McCaw General Hospital, Walla Walla, Wash., as chief of women's surgery.

\* \* \*

Comdr. Marvin B. Goldstein, Youngstown, has been chief dermatologist at a naval hospital in New Guinea for over a year. He was previously stationed at the naval training station, Newport, R. I.

\* \* \*

News from the Fronts, about Cleveland medics, from The Bulletin of The Academy of Medicine of Cleveland: Lt. Col. James R. Bell, post surgeon, Harmon Field, Stephenville, Newfoundland, North Atlantic Division, Air Transport Command. . . . Maj. E. Beshara, a division psychiatrist, was in Czechoslovakia on V-E Day. . . . Lt. W. S. Mozden, on a Coast Guard PF in a destroyer squadron, doing convoy and anti-submarine work, has made a couple of trips to Oran. . . . After being at Southhampton, England, for nearly a year, evacuating casualties from hospital ships and LST's, Maj. W. M. Barth is now

stationed about nine miles from Bournemouth, popular English watering place on the channel coast. . . . Maj. E. J. Humel rejoined his group in Mobile, Ala., following the usual 30-day leave after service in the E.T.O. . . . Lt. Col. G. R. Krause, in beautiful Hawaii, but "Honolulu itself is a dirty city, prices are outrageous, the place is overcrowded, and there is a rigidly enforced 10 P.M. curfew". . . . Maj. H. P. Limbacher, home on leave after service in Africa, Italy and Germany. . . . Capt. Robert McCaffery flew 14,000 miles in six days from the northern portion of the Ledo Road in Southern China, on an emergency leave due to the illness of his wife. . . . Capt. H. H. Roenigk, in India over a year, visited the Taj Mahal at Agra before he left, but likes the Terminal Tower better. . . . Lt. A. H. Schumacher, still in the Russell Islands, "this almost forgotten area". . . . Lt. J. S. Landes, with the 203rd General Hospital in a suburb of Paris. This hospital is the largest in the E.T.O., and of quite modern construction. It was built by the French and used by the Germans during the occupation of France.

\* \* \*

When Hideki Tojo, Japan's war premier, attempted suicide in Tokyo, Sept. 11, Capt. James B. Johnson, Jr., Newark, was the first American medical officer on the scene. His father-in-law, former Governor Vic Donahey commented: "My only hope is that Jimmie saves old Tojo so that we can hang him right!" Capt. Johnson is with the First Cavalry Division. He wears the Purple Heart for wounds received in the Battle of Leyte and was awarded the Bronze Star for rescuing an American soldier under enemy fire.

Another Ohio officer in on the case was Col. Roger Egeberg, Cleveland, personal physician to General Douglas MacArthur, who, according to an AP story, sent Col. Egeberg "to Tojo's bedside to try to save the Premier".

\* \* \*

The address of Dr. Morris W. Dexter, Cincinnati, assistant surgeon, U.S.P.H.S.R., on duty aboard the U.S.S. Orlando (P.F.99) has been changed from F.P.O., New York, to F.P.O., San Francisco.

\* \* \*

Commanding officer of a medical company of the Fifth Marine Division, "in the field", Lt. Comdr. W. L. Strohmenger, Cincinnati, has a good word to say for Ohio Medical Indemnity, Inc.

\* \* \*

Maj. William F. Ashe, Cincinnati, acting director, Nutrition Division, Office of the Surgeon General, recently returned from a tour of the Pacific inspecting the nutritional state of troops and studying the nutrition program of that theater. He was at Oahu, Johnston, Kwajalein,





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Saipan, Guam, Luzon, Leyte, Moratai, Biak and Hollandia, New Guinea. He expects to be assigned soon as chief nutrition consultant to the American public health officer on the Combined Council for the control of Germany. According to Dr. Ashe, nutrition is the No. 1 public health problem in Germany today. The United States has several nutrition teams operating in the American Zone of Occupation appraising the nutritional state of the people and supplying data to the food supply organizations concerning food requirements, a program which originated in the office of the Nutrition Division.

\* \* \*

Comdr. W. Stuart Henderson, Akron, was awarded the Navy's commendation ribbon for "high professional skill and initiative" in treating wounded aboard General Douglas MacArthur's command ship, the U.S.S. Nashville, which lost 133 men killed and 190 wounded through the attack of a Jap suicide plane.

\* \* \*

Maj. Norman H. Weinberg, Cincinnati, has been assigned to the staff of the Station Hospital, Camp Breckinridge, Ky., after 32 months as regimental surgeon for the 60th Infantry, Ninth Division, in Europe. He served in campaigns in Morocco, Tunisia, Sicily, and the E.T.O., and is entitled to wear the Bronze Star Medal and eight battle stars.

\* \* \*

Maj. Jay. P. Roller, Luckey, Wood County, is on inactive status after service in the E.T.O. with the 39th Infantry Division.

\* \* \*

Among many other far-off places, *The Ohio State Medical Journal* is now going to Salzburg, Austria, for the perusal of Capt. Carl J. Pater-nite, Toledo, who is in the medical detachment of the 756th Tank Bn.

\* \* \*

Maj. Kenneth A. Owen, Akron, on active duty for three years, has been chief of medical service in various A.A.F. hospitals, including Selfridge Field, Mich., Bolling Field, Washington, D. C., and now, Foster Field, Texas.

\* \* \*

Capt. James W. Norris, Columbus, is director of the Ob. and Gyn. Services at the A.S.F. Station Hospital, Fort Crook, Nebraska. The service consists of 30 obstetrical beds and ten gynecological beds. Dr. Norris was recently elected a diplomate of the American Board of Obstetrics and Gynecology.

\* \* \*

The work of the Army Medical Department is far from over, Major General Norman T. Kirk, Surgeon General of the Army, said in the course of a talk at the recent dedication of Madigan



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General Hospital at Fort Lewis, Washington. The patient population of Army hospitals reached an all time high with 312,000 listed on August 14, General Kirk stated. "When it is considered that the average period of hospitalization of our battle casualties is about five and a half months after they arrive in a United States hospital, it can readily be seen that the work of the Army Medical Department does not stop with the cessation of hostilities", General Kirk said.

\* \* \*

Capt. Oscar A. Axelsson, Youngstown, has received the Bronze Star Medal for meritorious service in support of combat operations in France, Belgium and Germany. Divisional surgeon with the headquarters company of the Third Armored Division, Capt. Axelsson has been overseas two years and is now with the occupation forces in Darmstadt, Germany.

\* \* \*

After about four years with the Navy and Fleet Marine Force, Comdr. E. H. Hudson, Athens, has resumed his position as Director of the Student Health Service at Ohio University.

\* \* \*

Sending the good news that he is now in the process of being returned to the States, Capt. A. Novinsky, Bethel, with the 30th Abn. Medical Company, 82nd Airborne Division, reports that *The Journal* never failed to reach him even during combat, in the two and a half years he was overseas.

\* \* \*

Capt. B. M. Brandmiller, Youngstown, writes that 22 months in New Guinea didn't give him much opportunity to keep in touch with medical subjects, but facilities in Luzon are much more accessible. He is with the 593rd E.B.S.R.

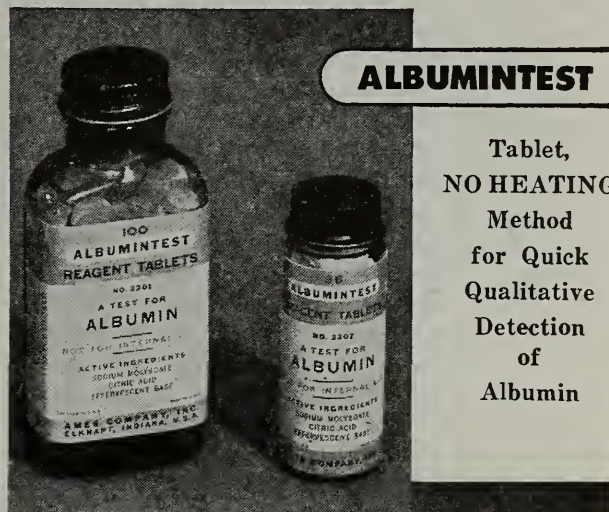
\* \* \*

Taken ill while medical officer for a squadron of mine sweepers off Okinawa, Lieut. (j.g.) Howard M. Schriver, Cincinnati, is now recuperating at the U. S. Naval Hospital, Corona, Calif.

\* \* \*

About Toledo medics, from *The Bulletin of The Academy of Medicine of Toledo*: Lt. Burton Scheib landed with the Marines on Okinawa . . . Lt. Col. M. A. Schnitker, home en route to the C.B.I. . . . Capt. M. Weinblatt, last heard from in Africa . . . Lt. Andrew Extejt, somewhere in Europe . . . Lt. Col. Max T. Schnitker, doing neurosurgery in a general hospital in India . . . Lt. Bernard Botsch, on his way to the Great Lakes and another assignment . . . Lt. Col. Bernard Pelton, medical inspector for the Far East Air Service Command . . . Maj. Matthew Ginsburg, on the U. S. Hospital Ship Ernest Hinds . . . Capt. J. N. Fidelholtz, running a dispensary in the Philippines . . . Maj. A. J. Kuehn, chief of anaesthesia and operating room section for the

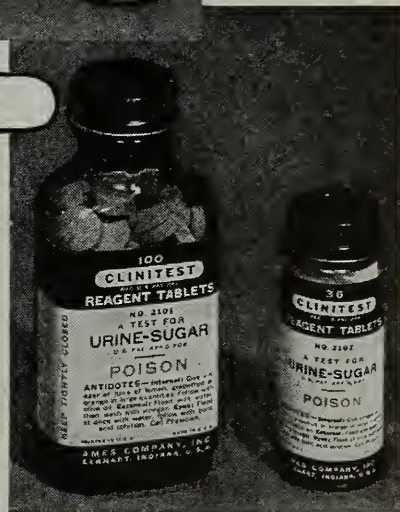
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1st General Hospital, the Bellevue unit, location not disclosed . . . Capt. E. Sternfeld, with the 135th Evacuation Hospital, saw Maj. Jos. B. Edelstein in Ronen. The 135th was scheduled for direct redeployment to the C.B.I. Maj. J. M. Hertzberg, left New Guinea for the Philippines, reports very little left of Manila, now in Luzon . . . Capt. F. W. Epstein, doing dermatology at Walter Reed General Hospital, Washington, D. C., where Capt. Jos. Radecki is an anaesthetist . . . Capt. M. Selman, enjoying the sights of Paris en route to a new assignment . . . Comdr. A. R. Klopfenstein, on the staff of the Surgeon Hq., Fleet Marine Force Pacific since last November, has added the Fourth Marine Division Presidential Unit Citation to his other ribbons . . . Capt. Walter A. Johnson, transferred from the 82nd Airborne Division to the 17th Airborne Division for deployment home, after 28 months in the E.T.O. Six battle participation stars, Purple Heart with cluster and a Bronze Star Medal helped him amass a total of 100 points . . . Lt. Col. Newton C. Spencer, still in the E.T.O. with the Air Disarmament Division of the Hq. IX A.F. Service Command, spends most of his time traveling around Germany. He has covered the American sector from Bremen to the Brenner Pass. The main concern of the division is to collect all information and equipment of technical intelligence value and forward it to Wright Field, Dayton.

\* \* \*

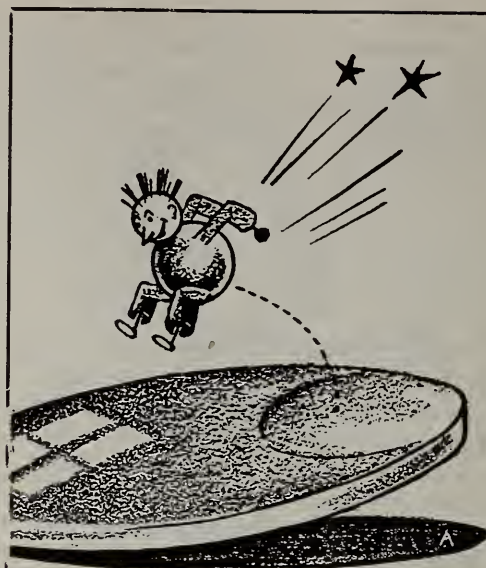
Rescue work under fire at Manila on Feb. 3, 1945, earned the Silver Star for Capt. James I. Rhiel, Columbus, overseas 26 months with the First Cavalry Division.

\* \* \*

The present duties of Capt. S. E. Gates, Conneaut, as combat surgeon for C.C.A. of the Third Army at Coburg, Germany, include the responsibility for public health in three counties. This job is considerably different than his assignment prior to V-E Day, when Capt. Gates was battalion surgeon for the 60th Armored Infantry, 9th Armored Division. His outfit was in the Battle of the Bulge and spearheaded the First Army at Remagen. There he stopped some lead from an 88 but was back on duty in time for the kill. Capt. Gates has the Silver Star, Bronze Star with cluster, Purple Heart with cluster, Combat Medics' Badge and three battle stars. He hopes to get home in October or November.

\* \* \*

Here and there with Youngstown medical officers, from The Bulletin of the Mahoning County Medical Society: Lt. Andrew A. Detesco, in the Pacific for 13 months, as medical officer for the 12 ships in L.C.I. Group 61. His unit was on the initial landing at Okinawa . . . Maj. Henry Sisek, after 36 months in the Pacific, including seven at Leyte, now at Billings General Hospital,



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Ft. Benjamin Harrison, Ind. . . Maj. Asher Randall, chief of the gastroenterology section of the 51st General Hospital in Manila . . . Capt. Densmore Thomas, with a medical battalion of the 38th Inf. Division in Luzon, in July . . . Capt. John A. Rogers, with the 35th Field Hospital, supervising the care of German P.O.W.'s, in Aversa. The hospital is staffed with German medical officers, medical students and "females who would correspond to our WACs".

\* \* \*

Capt. Ralph L. Phillips, Columbus, a battalion surgeon with the 37th Division, was awarded the Silver Star for outstanding gallantry in saving the life of a wounded soldier during the bitter battle for Plaridel, 20 miles north of Manila.

\* \* \*

Maj. John T. Gibbons has returned to Celina, after having been released from Torney General Hospital, with a medical retirement as of Sept. 2, 1945.

\* \* \*

Capt. Francis J. Denning, Steubenville, with the 86th Air Service Squadron, reports that he has received *The Journal* regularly during the 28 months he has been in the India-Burma theater.

\* \* \*

New locations within the United States: Maj. Guy Brugler, Cleveland, Woodrow Wilson Hosp., Staunton, Va.; Capt. Paul E. Reading, Painesville, 663rd Clearing Co., Camp Swift, Texas; Maj. Boyd D. King, Cleveland, Kennedy Gen. Hosp., Memphis, Tenn.; Lt. Comdr. Orville M. Wright, Dayton; Personnel Grp., Hq. Sq., Miramar, San Diego, Calif.; Maj. Chas. W. Elkins, Cleveland, Newton D. Baker Gen. Hosp., Martinsburg, W. Va.; Maj. Irwin C. Hanger, Cleveland, Crile Gen. Hosp., Cleveland; Capt. W. A. Neill, Toledo, U. S. Naval Hospital, Oceanside, Calif.; Capt. E. A. Volzer, Canton, Vet. Admr. Branch Office, Cuyahoga Bldg., Cleveland; Capt. R. C. Suttle, Put-in-Bay, 110 A.A.F.B.U., Mitchell Field, N. Y.; Capt. Wayne C. Smith, Van Wert, 301st A.A.F. Base Unit, (C.A.P.) Drew Field, Tampa, Fla.; Capt. Horatio T. Pease, Wadsworth, 1560 S.C.U. Sep. Ctr., Med. Branch, Camp Atterbury, Ind.; Lt. Col. J. E. McCarthy, Cincinnati, 112th Gen. Hosp., A.S.F.T.C., Fort Lewis, Wash; Lt. R. A. Kidd, Jr., Columbus, Naval Training Station, Chicago, Ill.; Maj. Morris M. Kessler, Cleveland Heights, Valley Forge Gen. Hosp., Phoenixville, Pa.; E. L. Glicksberg, Cleveland, Camp Crowder, Mo.; Capt. Stephen V. Geroch, Akron, Sta. Hosp., A.A.B., Ephrata, Wash.; Comdr. Stanley Gardner, Cleveland, U. S. Naval Hospital, Great Lakes, Ill.; Capt. A. N. Freed, Shaker Heights, 109th Gen. Hosp., Ft. Lewis, Wash.; Lt. Col. Carl T. Doeing, Springfield, Sta. Hosp., A.A.F.,

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\* \* \*

Stationed at Biggin Hill, England, Capt. George I. Scheetz, Rockford, is flight surgeon for the 314th Air Transport Squadron, 31st Air Transport Group, which has been in England doing transport flying of all kinds including air evacuation of wounded from the continent. Capt. Scheetz says that this group was the first to bring back wounded after D-day; first into Germany—often picking up patients before the landing strips were complete. He is now the only American medical officer at the field, and with the help of an R.A.F. physician looks after the medical needs of the station, the only one through which leave-personnel from the continent can enter the United Kingdom.

## WIN PROMOTIONS

| Name                    | City                  | Rank               |
|-------------------------|-----------------------|--------------------|
| Ackerman, Garrett B.    | Columbus.....         | Capt., U.S.A.      |
| Clodfelter, H. M.       | Columbus.....         | Comdr., U.S.N.     |
| Coleman, Marion.        | Dayton.....           | Capt., U.S.N.      |
| Craddock, Wm. H.        | Cincinnati.....       | Lt. Col., U.S.A.   |
| Detesco, Alfred A.      | Youngstown.....       | Lt., U.S.N.        |
| Evans, W. H.            | Youngstown.....       | Comdr., U.S.N.     |
| Fisher, Comdr. J. L.    | Youngstown.....       | Comdr., U.S.N.     |
| Goldstein, Marvin B.    | Youngstown.....       | Comdr., U.S.N.     |
| Grigsby, Robt. E.       | Cincinnati.....       | Lt. Col., U.S.A.   |
| Heller, Glenn H.        | Akron.....            | Major, U.S.A.      |
| Hellwig, Edward F.      | Cleveland.....        | Lt. Col., U.S.A.   |
| Henderson, Wm. S.       | Akron.....            | Comdr., U.S.N.     |
| Heringhaus, Francis J.  | Mansfield.....        | Lt. Col., U.S.A.   |
| Hertzberg, Joseph M.    | Toledo.....           | Major, U.S.A.      |
| Hillabrand, John F.     | Toledo.....           | Lt. Comdr., U.S.N. |
| Huth, Paul O.           | Cambridge.....        | Comdr., U.S.N.     |
| Kahn, Joseph R.         | Cleveland.....        | Major, U.S.A.      |
| Keidel, Clifford L.     | Cleves.....           | Major, U.S.A.      |
| Kelly, Donald A.        | Cleveland.....        | Lt. Col., U.S.A.   |
| Kelly, Fred R.          | Cleveland.....        | Lt. Col., U.S.A.   |
| Keogh, Jos. P.          | Youngstown.....       | Lt. Comdr., U.S.N. |
| MacMillan, Robt. J.     | Cincinnati.....       | Capt., U.S.A.      |
| Markley, Wm. W.         | Cleveland.....        | Capt., U.S.A.      |
| Maurer, E. P.           | Cleveland.....        | Capt., U.S.A.      |
| McGaw, Wilbert H.       | Cleveland.....        | Lt. Col., U.S.A.   |
| Norris, James W.        | Columbus.....         | Capt., U.S.A.      |
| Obenour, Sterling W.    | Zanesville.....       | Comdr., U.S.N.     |
| Osgood, Fred P.         | Toledo.....           | Comdr., U.S.N.     |
| Owen, Kenneth A.        | Akron.....            | Major, U.S.A.      |
| Pimsner, Arthur A.      | Lakewood.....         | Lt. Col., U.S.A.   |
| Rhiel, James T.         | Eaton.....            | Capt., U.S.A.      |
| Riemschneider, Edwin A. | Cleveland.....        | Lt. Comdr., U.S.N. |
| Smith, Herman C.        | Cleveland.....        | Lt. Col., U.S.A.   |
| Smith, Robert G.        | Columbus.....         | Lt. Comdr., U.S.N. |
| Speicher, Clyde M.      | Cleveland.....        | Comdr., U.S.N.     |
| Strohenger, W. L.       | Cincinnati.....       | Lt. Comdr., U.S.N. |
| Sutton, M. B.           | New Philadelphia..... | Major, U.S.A.      |
| Thomas, James J.        | Alliance.....         | Capt., U.S.A.      |
| Toth, Daniel F.         | Cleveland.....        | Major, U.S.A.      |
| Weckesser, Elden C.     | Cleveland.....        | Major, U.S.A.      |
| Weinberg, H. C.         | Cleveland.....        | Major, U.S.A.      |
| Wood, Cyrus R.          | Port Clinton.....     | Lt. Col., U.S.A.   |

More News from the Fronts, from The Bulletin of The Academy of Medicine of Cleveland: Lt. (j.g.) S. E. Burkhart, stationed at U. S. Naval Barracks, Tampa, Fla., following a tour of duty at Okinawa. His senior medical officer is Dr. J. Slivka. . . . Capt. D. N. Goodman, just finished an assignment servicing P.O.W. stockades in the Rhineland around Remagen, a responsibility taken over by French forces . . . Capt. Jacob M. Werle, in the vicinity of Marseilles, doing neurosurgery, 16 months overseas, with 83 points. . . . Lt. Col. Robert E. Bowman, "vacationing at government expense" quartered in a small hotel in Traben-Trarbach in the Mosel

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River Valley. Has used tons of DDT spraying German prisoners and displaced persons. "It is marvelous stuff, and should rate with penicillin and some of the other great drugs of the war." . . . Comdr. Stanley Gardner, reporting soon to the U. S. Naval Hospital, Great Lakes, as chief of anesthesia. . . . Lt. Col. A. A. Pimsner, assigned to Camp Breckinridge, Ky., and Lt. Col. J. H. Lazzari, to Crile General Hospital, Cleveland, after three and a half years in the South Pacific. . . . Capt. R. R. Miller, at Camp Crowder, Mo., awaiting redeployment after 13 months in England. . . . Capt. S. Hayashi, post surgeon at a P.W. camp in France. . . . Capt. Thomas A. King, still in Germany, has seen a lot of Cleveland medical officers, including Drs. Warren Hastings, Jacob Werle, Mose Black and Bert Bradford. . . . Capt. Hastings, neurosurgeon with the First Army, is awaiting orders in Czechoslovakia. . . . Lt. (j.g.) Les Parker, happy that he has been transferred from a destroyer and is now doing surgery to a landing and hospital ship. . . . Lt. Comdr. Ed Riemen-schneider, land-based on Guam, after quite a long stretch on a hospital evacuation ship, including action at Iwo Jima and Okinawa. . . . Capt. Newt Spears, reported to be on his way to the Pacific, after duty as a county public health officer in Germany, with headquarters in a former concentration camp near Seigen. . . . Drs. Jim Donnelly, Fred Rose, Herb Johnson, Lew Bronson and Jack McKay, formerly with the Lakeside Unit in the Pacific, now on medical service at Moore General Hospital, Swannanoa, N. C. This service is headed by Lt. Col. Joseph Hayman. . . . Capt. Jerry Kent, in Paris taking a refresher course and slated to return to his infantry division.

\* \* \*

Maj. John G. Anderson, Lynchburg, has been awarded the Bronze Star Medal, for "meritorious achievement in connection with military operations against the enemy" on Mindanao Island, the Philippines. Assistant surgeon at Headquarters, Tenth Corps, Major Anderson has been overseas 14 months in New Guinea, Leyte and Mindanao, and has coordinated the evacuation of patients during two military campaigns.

\* \* \*

News about Cincinnati medics from the Cincinnati Journal of Medicine: Lt. Col. John W. Leichter, with the 27th Medical Laboratory, on Leyte, starting his second year in the South Pacific . . . Aboard the U.S.S. Hinsdale, Lieut. Taylor W. Barker was at Iwo Jima on D-Day and later at Okinawa . . . Capt. Edward J. Geiser, with the 304th General Hospital on Pinon Island in the Mariannas . . . Lt. Col. B. Noland Carter, home on leave from his duties in the Office of the Surgeon General, Washington . . . Now in the de-



**THE VICTORY MEETING** of the Southern Medical Association will be held under the sponsorship of the Campbell-Kenton County Medical Society of Kentucky in Cincinnati, Ohio, November 12-15. It is a Kentucky meeting. The Southern Medical Association meetings always have been and always will be the essential meetings IN and FOR the South. The Southern as an essential medical organization has carried on without a break during the war—it has not missed a meeting. Now it will celebrate the victory with a great VICTORY MEETING. In its twenty-one sections, two general sessions, six conjoint meetings, and the scientific and technical exhibits, in a streamlined program, one will get the last word in modern, practical, scientific medicine and surgery.

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**ALL WHITE MEMBERS** of the OHIO STATE MEDICAL ASSOCIATION are cordially invited to be the guests of the Southern Medical Association at the Cincinnati meeting. Attending guests will be accorded every privilege of members except voting in the business session. No registration fee.

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partment of urology, Nichols General Hospital, Louisville, Ky., Capt. Harry O. Lepsky was in the South Pacific for 25 months . . . Capt. Robert E. Khuon, home on convalescent leave after two years with the A.A.F. in the China-Burma-India theater . . . Capt. Ralph J. Kessler, with the 313th Medical Bn., at Lake Gardia, near Desenzano, Italy . . . Transferred from the 25th General Hospital, Capt. Sander Goodman in Southern France, awaiting orders . . . Capt. Edward J. Devins, assistant chief of staff, Station Hospital, Camp Gruber, Okla. . . . Lieut. Lester J. Bossert on the cargo ship, U.S.S. Chelet, AK 138, in the South Pacific . . . Formerly with the 313th Station Hospital and the 159th General Hospital in England, Maj. William F. Hunting is now chief of the contagious disease section of the Station Hospital at Camp Campbell, Ky. . . . Lt. Comdr. Joseph Bolin, doing the X-ray work for Special Augmented Hospital No. 6 on the Ryukyus, has been in close touch with Dr. Howard M. Schriver (since returned to the States), and Drs. W. O. Ramey and Kent E. Martin . . . Maj. Herbert J. Brinker, on terminal leave, after active duty since March 14, 1941. He landed with the 2nd Auxiliary Surgical Group in Casablanca in Feb., 1943, went to Italy in Sept., 1943, was in the invasions at Anzio and Southern France, accompanied the Seventh Army into Germany, became chief of surgical service with the 229th General Hospital in Vallenciennes, France, and when the 229th was assigned for shipment to the Philippines, he concluded his foreign service with the 30th General Hospital, the University of California Unit, at Antwerp, Belgium . . . Capt. John W. Hauser, returned to civilian practice, after three years in the service including 27 months in the E.T.O. While chief of the urological section for the 38th Station Hospital in England, Capt. Hauser was injured in an automobile accident, and for the past six months has been at Wakeman General Hospital, Camp Atterbury, serving in the dual capacity of convalescent patient and assistant in the department of urology.

\* \* \*

Lt. Comdr. John C. Danahy, Cincinnati, has been authorized to wear the Commendation Ribbon "for distinguishing himself by excellent service aboard a vessel in her action against the enemy in the Southwest Pacific Area". In the service since August, 1942, Dr. Danahy has been overseas 18 months and now is stationed at a naval hospital on Guam.

\* \* \*

**More changes of location:** Capt. Olan P. Burt, Columbus, Reg. Hosp., Westover Field, Mass.; Lt. Samuel Schwebel, Youngstown, N.A.A.S. Burin Field, N.A.T.B., Pensacola, Fla.; Lt. Philip D. Weems, Portsmouth, U.S.N.R. Armory, Toledo; Maj A. L. Sparks, Warren, Sta. Hosp., Camp Roberts, Calif.; Comdr. C. M. Speicher.

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\* \* \*

Captain Harry L. Katz, M. C., Cleveland, Ohio, successfully passed the written examination for Fellowship in the American College of Chest Physicians held in June, 1945, and will be awarded his Fellowship Certificate at the next Convocation of the College to be held in conjunction with the annual meetings of the College which will again be resumed in 1946.

\* \* \*

Maj. Joseph M. Miller, Marion, is (or was) out on Okinawa heading up the 401st Med. Thoracic Surgical Detachment.

\* \* \*

Back in the States after three years overseas, including two years as a P.O.W. in Germany, Maj. Wilbur E. McKee, formerly of Bryan, expects to be separated from the service soon and plans to practice in Kentucky. Maj. McKee was taken prisoner in North Africa early in 1943 while in action with the 1st Armored Regiment.

\* \* \*

Capt. D. L. Friedman, Toledo, home on leave after service in the E.T.O. with the 1st Auxiliary Surgical Group, reports that he is headed for Ft. Douglas, Utah, but with 94 points, hopes to be back in mufti soon.

\* \* \*

Brig. Gen. James S. Simmons, Chief of the Preventive Medicine Service, Office of The Surgeon General, who has recently returned from an inspection trip of preventive medicine activities in the Pacific theaters of war, spoke on "Progress in the Army's Fight Against Tropical Diseases" at the 50th anniversary meeting of the Alpha Kappa Kappa Medical Fraternity of the University of Michigan, Ann Arbor, Mich. Highlights of his report follow:

**Malaria:** At one time in the Southwest Pacific, casualties from malaria were high and more than 30 per cent of the hospital beds were occupied by malaria patients. Now, due to widespread suppressive use of atabrine and to the establishment of good mosquito control in all base areas, admission rates from malaria have decreased markedly.

**Dengue:** A peak rate of 138 per 1,000 per annum occurred in Pacific Ocean Areas in September, 1944. An outbreak on Saipan subsided abruptly following the spraying of DDT by airplanes. Since then rates in that theater have been below 30 per 1,000 per annum.

**Diarrhea and the Dysenteries:** Rates reflect general sanitary conditions, including food and water sanitation and fly control. The new insecticide, DDT, is greatly simplifying the control of flies in latrines, mess halls and kitchens. On the whole, the situation in Pacific Ocean Areas has been satisfactory.

**Scrub Typhus:** We now have effective methods for the control of this disease by attacking the mites which transmit it.

**Infectious Hepatitis:** Great progress has been made in the study of the epidemiology of this

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disease by Commission members of the Army Epidemiological Board, and the work is continuing.

**Filariasis:** Its incidence at present is not alarming. Mosquito control prevents this disease.

**Schistosomiasis:** On Leyte all dangerous streams have been posted with signs warning the troops against the dangerous Japanese blood flukes. Educational teams are being developed to travel from unit to unit to acquaint the troops with the dangers of bathing or wading in infested fresh water.

In conclusion General Simmons said that he was proud of the way the Medical Department has carried out the Army's program of preventive medicine, and of the remarkable results obtained.

### Those Receiving Cash Benefits Eligible To Complete E. M. I. C. Services

Several State health-agency officials have requested that an interpretative policy statement be issued to clarify the recommendations of the Children's Bureau with reference to use by recipients of emergency maternity and infant care of medical and/or hospital prepaid service benefits under voluntary plans.

The basic policy governing this question is given in Emergency Maternity and Infant Care Information Circular No. 1 (Revised March, 1945), Section II, 9, which reads as follows:

"Physicians' services will not be authorized if the patient or someone in behalf of the patient is to pay for hospital care; and hospital care will not be authorized if the patient or someone in behalf of the patient is to pay the physician for medical care."

In order to clarify the question regarding the use of medical and/or hospital service benefits by recipients under the emergency maternity and infant program the following policy statement is issued, effective July 1, 1945:

Prepaid medical and/or hospital service benefits for maternity or infant care are considered as payments made in behalf of the patient; however, cash-indemnity insurance benefits paid to the insured are not considered as payments made in behalf of the patient.

This policy statement, it is believed, is consistent with the original intent of Section II, 9, and is in conformity with the basic philosophy of the emergency maternity and infant care program, that services are to be made available to all eligible wives and infants on the same basis and without regard to their economic resources. Use of prepaid service benefits for maternity and infant care would greatly reduce services available to service men's dependents for other illnesses, because many prepaid and/or hospital benefit contracts limit the care for which payment may be made in a given period of time.—Republished from *The Child*, publication of U.S. Children's Bureau, July, 1945.

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## Museum Acquires Rare Models

The 100 R. L. Dickinson sculptural models of human reproduction have been acquired by the Cleveland Health Museum for display and for distribution to medical, nursing and health groups. The acquisition was made possible through the Prentiss Foundation. Part of Dr. Dickinson's exhibit was shown for the first time at the New York World's Fair Hall of Man, where Dr. Bruno Gebhard, now director of the Cleveland Health Museum, was technical consultant. The collection includes: Standard figures of adult male and female, and of newborn baby; pregnancy and labor; anatomy of male and female reproductive organs; venereal diseases; some surgical operations; full-size manikin for teaching medical students delivery; the World's Fair series of childbirth in successive stages; six small models for the doctor's desk for explanation to patients or students; and others for specialized uses.

Trustees of the Cleveland Health Museum have approved plans for purchase of the building formerly known as Garfield House, 8917 Euclid Avenue, occupied by the Cleveland Speech and Hearing Center, to be used primarily to accommodate the Dickinson collection. However it will be used also to augment space for other existing exhibits and for new exhibits planned to cover mental hygiene, industrial health, and a new series pointing the way toward a healthier and happier old age; to furnish additional space for the health education laboratories, particularly the new plastics department; and to give increased facilities for teaching in the postgraduate field of health education.

**Zanesville**—Dr. C. J. Roach has been re-elected president of the staff of Good Samaritan Hospital. Other officers are: Dr. H. B. Kaufman, vice-president and Dr. R. S. Martin, secretary.

**Wadsworth**—Dr. H. H. Biggs, located here for over 25 years, has retired from practice because of ill health.

**Geneva**—Dr. E. H. Merrell has been elected president of the Booster Club, an organization formed to promote athletic events.

**Springfield**—The new superintendent and medical director of the Clark County Tuberculosis Sanatorium is Dr. William P. Habeeb, for the past three-and-one-half years superintendent of the Pinecrest Sanatorium, Beckley, W. Va.

**Loveland**—Dr. and Mrs. Austin C. Roberts celebrated their 60th wedding anniversary on Aug. 27. Dr. Roberts retired in 1940 after having practiced in Wilmington and Morrow for many years.

**Lorain**—"Life After Forty", was the subject of a talk made by Dr. Benjamin Carlson at a meeting of the Kiwanis Club.

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# Do You Know - - -

Governor Tobin of Massachusetts recently vetoed a bill which had passed both the Senate and House in that state, proposing to set up a separate board for the licensing of chiropractors.

\* \* \*

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7 and 8, 1945, at the Mayflower Hotel, Washington, D. C. At this time approximately 200 men will receive their fellowship. A scientific program is planned for both days.

\* \* \*

General Motors Corporation has announced a \$4,000,000 grant by the Alfred P. Sloan Foundation to establish a Sloan-Kettering Institute for Cancer Research at the New York Memorial Center. Charles F. Kettering, director of research for General Motors, will direct the organization. The institute will study the causes of cancer, and seek better methods of treatment and possible cures.

\* \* \*

Dr. William L. Potts, Tampa, Fla., is the new medical director-superintendent of the Franklin County Tuberculosis Hospital and controller of tuberculosis in Franklin County. For the past three years, Dr. Potts has held a similar post for Hillsborough County, Tampa, Fla. He succeeds Dr. Myron D. Miller, who resigned recently to join the U. S. Public Health Service.

\* \* \*

Col. Paul W. Tibbets, Jr., who piloted the plane which dropped the first atomic bomb on Japan, was a pre-med student at the University of Cincinnati in 1936 and 1937. He was in Cincinnati on July 13 and visited Dr. and Mrs. A. Harry Crum, with whom he made his home while a student. Col. Tibbets left college in 1937 to begin his training in aviation.

\* \* \*

School children will receive better medical care in the future as communities supply more funds for health service within the schools, Dr. Carl A. Wilzbach, Cincinnati health commissioner, told more than 100 Ohio school men and women at the second annual Miami Workshop at Miami University, Oxford.

The use of a war-developed chemical to eradicate ragweed is being considered by the State Department of Health as a means of bringing relief to Ohioans who suffer from hay fever.

\* \* \*

Dr. Clarence E. Spears, whose 28-year football coaching career included eight years at the University of Toledo, has resigned as coach at the University of Maryland to enter the practice of medicine.

\* \* \*

The National Advisory Cancer Council has made a grant of \$10,000 to the University of Cincinnati College of Medicine for clinical studies of gastric cancer to be conducted by Dr. Leon Schiff, associate professor of medicine.

\* \* \*

The number of poor relief cases in Ohio dropped in August, 1945, to 10,592, a record low, according to the State Department of Public Welfare.

\* \* \*

Bids are being received for the construction of a new \$900,000 unit at the Ohio State Sanatorium at Mt. Vernon for the housing of approximately 750 tubercular patients now in state mental hospitals.

\* \* \*

Dr. Robert M. Stecher, assistant professor of clinical medicine, Western Reserve University School of Medicine, Cleveland, spoke on "Arthritis and Gout", Sept. 19, at Kansas City, Mo., under the auspices of the Jackson County Health Forum.

\* \* \*

Construction of new research laboratories, costing more than \$2,000,000 for Winthrop Chemical Co. has been announced by Dr. Theodore G. Klumpp, president, as he disclosed purchase of a 60-acre site at Rensselaer, N. Y., for the purpose. Situated close to Winthrop's present plant and laboratory facilities, the new structure will replace the existing research laboratories. In addition, Sterling Drug, Inc., of which Winthrop is a subsidiary, will utilize the new laboratories to supplement the research of its other units.

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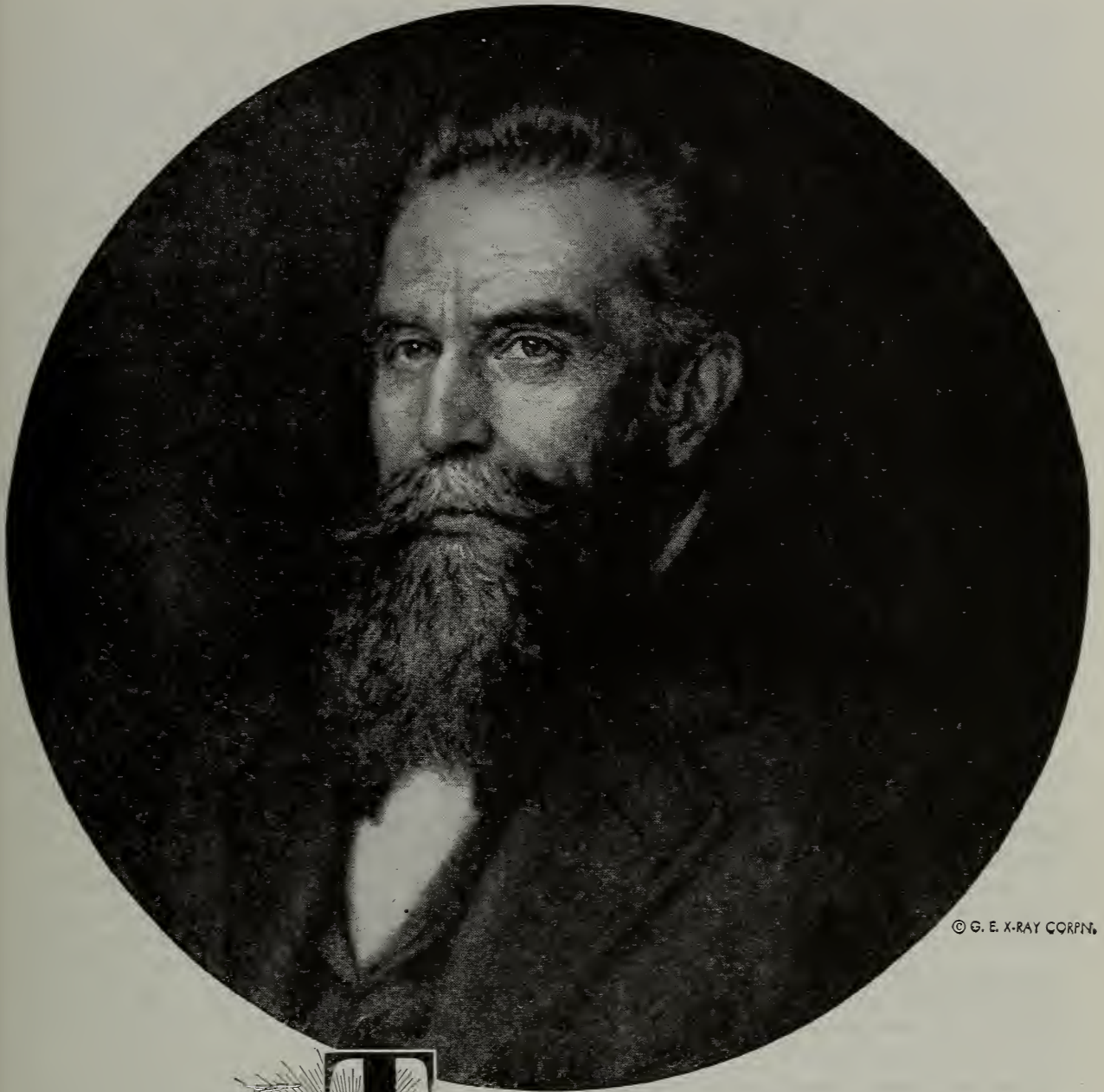
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**T**HE new light became visible like a dazzling meteor in the evening of the nineteenth century. It surrounded the morning of our own century with the rosy light of hope and promise. Like a glittering sun it shines resplendent on the working day of the twentieth century, revealing new fairways and fresh horizons in nearly every land in the world of science. . . . In commemorating William Conrad Roentgen this year—the centennial of his birth, also the semi-centennial of his discovery of the x-ray—one is inspired anew by the above tribute spoken by Dr. Gosta Forssell, of Stockholm, Sweden, before the Fifth International Congress of Radiology, held in Chicago in 1937.

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# The Physician's Bookshelf

**The Way of an Investigator**, by Walter B. Cannon, M.D., (\$3.00. *W. W. Norton & Co., New York City*) sets forth in lively fashion the author's experiences in medical research. In addition, he has recorded here many of his own observations and judgments. It therefore is a book which should appeal to those engaged in medical investigation, but every physician will profit much by reading it.

**Management of Obstetric Difficulties**, by Paul Titus, M.D., (\$10.00, 3rd Ed. *The C. V. Mosby Co., St. Louis*) brings this excellent monograph up to date. The chapter on X-ray has been written. A new classification of toxemias is proposed. Caudal analgesia, Rh factors, penicillin, are some of the subjects of the new material. Certainly, these advancements are going to affect maternal mortality most favorably. Our rate of 45.3 in 1941 as compared with 82.3 in 1919 is cause for rejoicing, but surely is not an irreducible minimum. But we know that one-third of the 1930-32 maternal deaths were due to failure to make use of the facilities at her disposal. Nevertheless, we bear the responsibility for 60 per cent. Books like this one will help mightily.

**Oral Pathology**, by Kurt Thoma, D.M.D., (\$15.00. 2nd Ed. *The C. V. Mosby Co., St. Louis*) presents a revised study of histological, roentgenological, and clinical factors in diseases of the teeth, jaws, and mouth. Since this is an area too often neglected in our teaching and our practice, this volume would make a helpful addition to our libraries.

**Courage and Devotion Beyond the Call of Duty**, (Preliminary Ed. *Mead Johnson & Co., Evansville, Ind.*) contains the full text of the citations of some 250 medical officers.

**Facts for Childless Couples**, by E. C. Hamblen, M.D., (\$1.50. *Charles C. Thomas, Publ., Springfield, Ill.*) This should be in the hand of every partner to a sterile marriage. For the physician it will serve a useful purpose. For the harassed medical student it will come as a God-send to clarify his misunderstandings of endocrinology.

**Manual of Clinical Mycology**, (\$3.50. *W. B. Saunders Co., Philadelphia*) was prepared by four members of the faculty of Duke University for the military forces. It is, of course, a handy volume on this complicated and too little known field of medicine.

**Ventures in Science of a Country Surgeon**, by Arthur E. Hertzler, M.D., (Published Privately. *Halstead, Kansas*) tries to show the relation of preclinical sciences to the life of a surgeon for the good of seven grandchildren who seem to be headed for the profession of medicine.

**The Art of Medicine in Relation to the Progress of Thought**, by A. E. Clark-Kennedy, (\$0.75. *Cambridge University Press, The Macmillan Co., New York City*) was presented as a lecture in the History of Science in the University on February 10, 1945. It is a most delightful little volume.

**Medicine and the Neuroses: A Report of the Hershey Conference on Psychiatric Rehabilitation**, (*Apply, The National Committee for Mental Hygiene, 1790 Broadway, New York City 19*), is a call for prompt action in meeting a long standing need of internal medicine and psychiatry. It is the product of three days of serious deliberation by thirty leaders in both fields.

**Government in Public Health**, by Harry Stoel Mustard, M.D., (\$1.50. *Commonweath Fund, New York City*) is one of the series of the Committee on Medicine on Changing Order of the New York Academy of Medicine. It describes local responsibility for public health activity and the growing interest and concern for public health programs on the part of the state and federal governments.

**Life Begins with Marriage**, by Theodore G. Mitchell, (\$2.75. *Dearborn Publishing Company, Chicago*) is a sensible discussion of marriage emphasizing intelligent cooperation in man-made joys and pleasures because people have all the natural ones in common.

**Music for Your Health**, by Edward Podolsky, M.D., (\$2.00. *Bernard Ackerman, Inc., New York City*) is a thorough study of the subject which the author began in his *The Doctor Prescribes Music* (1939). This volume not only tells the story but serves as a manual with charts, diagrams, and programs.

**Britain and Malaya**, by Sir Richard Winstedt, (*British Information Service, 30 Rockefeller Plaza, New York City*) tells the story of their relations between 1786 and 1941 in a most interesting manner.

**Diet Manual for Home Nursing**, by Marie V. Krause and Eleanor Sense (\$2.00. *M. Barrows & Company, Inc., New York City*) simply contains practical advice for the correct interpretation of the physician's food prescription. An important job well done.

**Facial Prosthesis**, by Arthur H. Bulbulian, D.D.S., (\$5.00. *W. B. Saunders Co., Philadelphia*) prescribes the methods of facial reconstruction in 225 pages and 202 illustrations. One of the first monographs bringing together this scattered literature. The author is the Director of Museum of Hygiene and Medicine at the Mayo Clinic.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

November, 1945

No. 11

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## The Management of Rheumatic Infection

WILLIAM H. BUNN, M.D.

IT is no military secret that there have been many thousands of United States soldiers and sailors in the past three years acutely ill of rheumatic fever. Many of these service men contracted the disease in the Rocky Mountain district, others in the southern states. This situation has revived interest in the prevention and treatment of rheumatic heart disease. At this time, there is no data to suggest that there has been a corresponding increase in the incidence of rheumatic fever among the civilian population. It is well known that approximately 35 per cent of patients with heart lesions have the rheumatic type of heart disease. It is estimated that there are approximately 400,000—500,000 cases of rheumatic heart disease in the United States at present. Fifty thousand draftees were rejected because of rheumatic cardiovascular disease. This tremendous public health problem justifies a review of our knowledge of a disease which has a high mortality and a very high morbidity rate.

The exact cause of rheumatic fever is still not definitely known but the mechanism of onset is more clearly understood than formerly. It appears almost certain that scarlet fever or infections, particularly of the nose and throat, with Group A hemolytic streptococci (often A-17 or A-30)<sup>1</sup> precedes the actual onset of an attack by several days or longer.

"For those who may not be familiar with the implications of this immunologic classification of hemolytic streptococci developed by Lancefield on the one hand and Griffith on the other, the following short resume is given: Streptococci are divided into groups on the basis of a carbohydrate-like substance designated as C which in the intact bacterial cells includes the formation of group-specific precipitins. About a dozen

### The Author

● Dr. Bunn, Youngstown, Ohio, is a graduate of Jefferson Medical College of Philadelphia, 1915; student of Sir James MacKenzie in Scotland; diplomate, American Board of Internal Medicine (for Cardiovascular Disease); fellow, American College of Physicians; member, Board of Directors of American Heart Association, and past-president, Central Society for Clinical Research; chief, Cardiac Clinic, and consulting physician, Youngstown Hospital.

groups have been identified. From the standpoint of human disease, group A is the most important, because it encompasses most of the hemolytic streptococci responsible for human streptococcal diseases. Group B is the most common inducer of mastitis in cattle. Group C causes many types of veterinary diseases. Group D includes the enterococcus, and members of this group are non-hemolytic and usually resistant to the sulfonamides. Group E includes many strains found in cheese. Groups F and G are recovered from human throats and may at times be pathogenic. The other groups have been recovered from various sources and have relatively less importance. In many groups non-hemolytic members also occur.

"Group A is divided into numerous types, designated by numbers. They were first separated out by Griffith with a slide agglutination technique; but Lancefield has shown that the immunologic specific substance for each type is a protein-like material called M. This M substance, when suitably extracted from the streptococcal cell, is employed in a precipitin test with a set of properly absorbed type-specific immune sera to classify the strains of streptococci in question. Over 45 types have now been identified, and many others have been found which do not fall into any of these now recognized. Thus, far, the majority of the strains recovered from

<sup>1</sup>Submitted Aug. 27, 1945.

human pathologic conditions have fallen into the first thirty types."

Following the initial streptococcal infection, properly termed the inducing infection and designated as Phase 1<sup>2</sup> of this disease, there is most often a quiescent period familiar to experienced clinicians. This period is usually 2-3 days but may be shorter or as long as 3 weeks. This should be labeled Phase II. It is during this stage of the disease that some unknown reaction occurs between the inducing streptococci and the tissue cells, most likely an antigen anti-body this reaction, Phase III, or true active rheumatic organism or virus by the streptococcus. After this reaction, Phase III, or true active rheumatic fever, exists as described in modern medical text books. From this disease, 73-86 per cent<sup>3</sup> of children and a smaller per cent of adults develop a heart lesion. An opportunity for introducing prophylactic measures and the proper treatment of rheumatic fever depends on a clear understanding of this conception of the disease.

The importance of the hereditary factor has been discussed by many writers particularly by Wilson, Schweitzer, and Lubschez.<sup>4</sup> Their observations of families in 109 homes in which there was at least one rheumatic patient extended over a period of from 6-20 years. They believe that susceptibility to rheumatic fever is definitely hereditary because case incidence follows the laws of inheritance. In their experience, rheumatic fever does not fit into the classification of a communicable disease due to any specific bacterial agent. They are not able to prove that contact with a patient either in the active or latent stage of the disease causes rheumatic fever in children with hereditary susceptibility.

It is difficult to reconcile entirely this idea of an inherited tendency with the recent experiences in Army and Navy camps. Coombs<sup>5</sup> reports that 10 per cent of the cases in a certain group have a positive family history, 14 per cent a probable, and 66 per cent a negative. Indirectly, crowded barracks must play a part in spreading the disease. When a group of soldiers isolated in a certain camp have the disease out of all proportion to the number found in a camp in almost the same location, it is difficult to believe that a specific infectious factor is not extremely important. This is especially impressive when the groups studied are living under like conditions of temperature, altitude, and diet, and are engaged in the same type of physical activities. However, Wilson's work can not be discounted for it was superbly done. Perhaps the difference is explained by the fact that she studied a younger age group.

The tendency for recurrences in rheumatic fever is well known. Some of those affected in service camps were men who had had a previous attack. Either their original infection had

been so slight that it was overlooked or the inductee falsified his previous history. In some instances, the medical examiner in his haste failed, on a sketchy examination, to find evidence of existing rheumatic cardiovascular disease.

#### PREVENTIVE MEASURES

The prevention of rheumatic heart disease is essentially the prevention of rheumatic fever for a high percentage of patients develop minimal or severe rheumatic heart disease. All too little can be accomplished after the disease has affected the endocardium. There is evidence that the sulfonamides if given prophylactically may reduce the incidence of acute rheumatic fever. The unanswered question is to whom shall we recommend such measures. Warren<sup>6</sup> and also Holbrook<sup>7</sup> have reported intensive and important studies on groups of soldiers and civilians which conclusively show that the incidence of streptococcal upper respiratory infections and scarlet fever is greatly lessened when the sulfonamides are given prophylactically. There is not complete agreement as to the exact dosage necessary but 1-1.5 gm. of sulfadiazine given daily "produced a continuous reduction in hospital admissions for respiratory diseases". Certain it is, that we are not yet in a position to advise this measure to the entire civilian population for there is some danger in sulfa-resistant strains developing.

However, we may be remiss in our duty if we fail to recommend that rheumatic fever be made a reportable disease so that during the time of the seasonal increase in the number of cases (Spring and Fall) or when there are several cases reported in the community, prophylactic measures may be applied promptly. If throat cultures were taken universally during epidemics of sore throat, the early discovery of hemolytic streptococcus-A producing a mucoid or matt growth<sup>8</sup> could be used as an indication for daily doses of sulfadiazine to the children and adolescents in that community.

The Army Air Forces have made an intensive study of streptococcal infections and have been able to control barrack infections of streptococcus A-17 and A-30 by oiling floors and blankets and other sound measures of hygiene. Some of these measures are practical for use in schools, colleges, hospitals, and children's homes.

In civilian practice, patients with a well developed heart lesion are seen frequently who have never had a day's serious illness in their lives. Obviously, nothing can be done by way of prevention in this group although we as physicians may have been negligent in not following patients with scarlet fever, throat, nose, and pharyngeal infections for longer periods. More patients, however, have a typical course with sore throat followed by polyarthritides and then



endocarditis. Too little attention has been given to this type of patient in the early hours of the infection.

It requires considerable persuasion to convince children and it is often difficult to convince parents that an ordinary sore throat is a potentially serious disease. They know as well as we do that most often such an infection has a short course followed by complete recovery. They must be instructed that sore throat is the typical forerunner of rheumatic fever and that if immediate treatment is instituted in this first phase of the disease (the exudative), fewer children may develop Phase II when any type of treatment is futile. Patients who recover slowly from a throat infection especially if they are pale, perspire easily, have a little evening rise of temperature, have an elevated white blood count, an increase in pulse rate, or an accelerated sedimentation rate most likely are in Phase II.

It is in the first hours before the activation of the streptococci or the antigen antibody reaction has occurred that salicylates or sulfa drugs may be effective if given in moderately large doses. The choice route for the administration of salicylate is by mouth (100-150 grains per day) for a child of average weight. There is some evidence to suggest that if large doses of sodium bicarbonate are given with the salicylate, the effectiveness of the salicylate is lessened. Enteric coated tablets are not as effective as the plain compressed tablet for most absorption occurs in the upper intestinal tract. Nausea and vomiting may occur unless small doses of sodium bicarbonate are given with the sodium salicylate to prevent the change to salicylic acid in the stomach. Studies made on blood salicylate levels show that the most effective range is 30-50 mg. per cent. However, except in special instances where there is a question of faulty absorption, it is not necessary to use blood salicylate levels as a guide to treatment.

A recent report of a case of salicylate poisoning during the treatment of rheumatic fever is reported by Fashena and Walker.<sup>9</sup> They found a greatly increased prothrombin time, more than five times normal. It was easily controlled, however, with vitamin K. This case serves to emphasize the necessity of closely watching for signs of intolerance whenever salicylates are given.

The patients who have a family background of rheumatic fever might be protected from the catastrophe of rheumatic heart disease by prophylactic use of sulfadiazine. Those who have had one attack of rheumatic fever should have the benefit of the lessened chance of reinfection to which they are so prone by giving them a daily dose of 1 gm. of sulfadiazine every month of the year except July and August. This measure has been tried<sup>10, 11</sup> and can be safely re-

commended. There have been surprisingly few severe reactions to the sulfadiazine given in this manner. There are some reactors and the usual precautions of careful observations during the first few weeks of the course must be carried out. Skin reactions were the most troublesome in the Navy program<sup>12</sup> but careful attention to early signs of agranulocytosis exfoliative dermatitis or other toxic manifestations made this risk less than chance of a recurrence of rheumatic fever and a resulting cardiac complication.

The use of sulfonamides not only for selected group prophylaxis but also for the treatment of Phase I of rheumatic fever is being tried with some success. It is certain that many proven streptococcus A infections of the throat subside rapidly when adequate doses of sulfadiazine are given promptly. Unfortunately, there are patients who go on into a typical course of rheumatic fever while taking the drug. A plan which we are not willing to abandon in spite of some failures is to give large doses of salicylates as described or 1 or 2 gm. of sulfadiazine for the first dose, followed by 1 gm. every 4 hours, hoping in this early application of the only known effective drugs that we may prevent the development of Phase II of rheumatic fever. T. Duckett Jones, with whom we have discussed this problem recently, is a sound clinician and investigator with a large experience in the care of rheumatic children. He is not too sanguine about being able to stop rheumatic fever once the die is cast but agrees that such prompt measures should be tried and carefully reported.

If we are to utilize this practical plan of employing drugs proved effective in the early stages of rheumatic fever, a technique must be devised for closer contact between the laboratory and the practicing physician so that reports on throat cultures will be treated as emergency items and will be given the same attention as throat smears in a suspected case of diphtheria. It may be that it is as essential to recognize streptococcal A sore throat and to treat it promptly with sulfa or salicylates or both as it is to use antitoxin in the treatment of diphtheria.

#### EARLY RECOGNITION AND TREATMENT

It is somewhat difficult to bring over into civilian practice certain procedures which are used in the Army where patients are under strict supervision. However, there are two points of difference: (a) A mother can be more watchful than a top sergeant and may observe symptoms earlier; and, (b) we are dealing with a younger age group in general practice. Two cases are cited which illustrate prompt recognition of infection and effective treatment.

Case 1. R. B., age 13, complained of chilliness and sore throat after school one evening. One



of his friends had come down with rheumatic fever one week before this episode. Throat cultures were promptly taken and an unidentified streptococcus found. His throat was terribly swollen and beefy red. The temperature was 103 degrees. He had a slight chill and suffered generalized muscle aching. Two gm. of sulfadiazine were given promptly and 1 gm. every four hours until 36 hours later when all symptoms had disappeared. Recovery was uneventful.

Case 2. C. A., female, age 16, whose sister had died one year before from acute rheumatic carditis. This child was found to have an asymptomatic mitral stenosis. She was sent to the hospital the afternoon of May 3 with a very angry looking throat which was covered with a slight membrane. The temperature was 104. She had a chill. The onset had been sudden, just a few hours before she was admitted to the hospital. The throat cultures showed an unidentified streptococcus. This patient was known to be sensitive to the sulfa drug, therefore, she was given 120 grains of salicylate in the first 24 hours and smaller doses thereafter. Her temperature came to normal the third day. The patient was discharged on the 14th day free of symptoms and no evidences that the previous existing heart condition had been exaggerated nor is there any such evidence to date, two months later.

Admittedly, these two case records prove little but suggest that prompt treatment for severe sore throat and prolonged convalescence may lessen the severity of the cardiac complications so commonly seen.

It is generally accepted that there is very little place in the treatment of the acute stage of rheumatic fever for the sulfonamides. In fact, Griffith et al.,<sup>13</sup> found that 11 cases in 240 were made worse by the drug. If a patient during the acute stage of the disease develops an acute hemolytic streptococcus, otitis media, tonsillitis, or sinusitis, this would constitute an indication for the employment of the sulfonamides or penicillin.

Although salicylates and sulfonamides are the choice drugs for the prevention of Phase I lapsing into Phase II, penicillin may prove to be useful for individuals who are sensitive to sulfonamides or who have been infected by a sulfa resistant organism. There is evidence that penicillin is not beneficial in the treatment of rheumatic fever; in fact, it may be harmful.<sup>14</sup>

Where chorea develops, Phase I has passed so that prophylactic measures are then of no avail. Three to 10 per cent of patients with uncomplicated chorea develop rheumatic heart disease. Sutton's 1938 experience<sup>15</sup> strongly suggests that fever therapy may definitely lessen the severity of subsequent cardiac lesions if applied properly.

There are no new developments in the clinical recognition of rheumatic heart disease per se. Elevated temperature, tachycardia, pericardial friction rub, murmurs in the various valve areas which appear in patients who have had sore

throats with or without polyarthrititis may be signs of active endocarditis. Premature contractions and other forms of arrhythmia may be early signs. There is an increasing tendency to give more weight to muscle aching, periarticular tenderness, and fibrositis as evidences of rheumatic activity. Elevation of sedimentation rate which may become normal during salicylate therapy frequently shows an acceleration shortly after the drug is withdrawn, increase of white blood cells in circulating blood, and changes in the conduction time in the electrocardiogram are additional signs which although inconstant may help to complete the diagnosis in patients in whom classical symptoms are rather vague. The appearance of nodules about the joints frequently offers confirmatory evidence. Erythema marginatum may occur early and persist.

During the acute stage of rheumatic heart disease, the only method of treatment is palliative. A great deal can be done to keep patients comfortable. There is no evidence that salicylate therapy even in massive doses influences in the least the duration or severity of the disease. The practice of giving large doses of salicylate intravenously is not without danger. It is well established that absorption of salicylate occurs in the upper intestinal tract. The method of choice is, therefore, sodium salicylate or acetylsalicylic acid, uncoated tablets, by mouth, and a small dose of sodium bicarbonate. The correct dosage is the amount required to control the joint pains and muscle aching. Small or moderate doses are usually sufficient. There is some evidence that large doses may produce alkalosis. However, no other drug alone or in combination produces the remarkable relief brought about by the salicylates.

If the patient is restless, small doses of phenobarbital,  $\frac{1}{4}$  to  $\frac{1}{2}$  gr. q.i.d., or small frequent doses of paregoric or other opiates may be used with good effect. Pillow splints for the joints, methylsalicylate applications, hot or cold packs for the affected parts or flannel wrappings for the tender areas are time honored and effective measures.

The course of the disease may be long and interrupted by deceptive periods of latency. If during this stage of the disease, throat, sinus, or ear infections occur, it is good practice to give one of the sulfonamides or penicillin to combat this particular complication especially if the causative organism is a group A streptococcus. If large pericardial effusions develop or if there is evidence of severe cardiac compression, it may be necessary to remove some of the fluid. If there is any reason to believe that the fluid is purulent, its complete removal or drainage should be promptly undertaken. If an abscessed tooth is discovered, it should be drained. Griffith, Leake, and Butt<sup>16</sup> will give statistical proof of



"the undesirability of removing teeth or tonsils until at least six months have elapsed after the patient has been thought to be in the quiescent state". Prior to this surgical procedure when it is finally undertaken, penicillin should be given (25,000 units every 2 hours starting 12 hours before surgery and continuing 24 hours after) to discourage a blood stream infection which not uncommonly follows dental surgery.

The complication of pyelitis and pyelonephritis is often discovered in children during the active stage of rheumatic heart disease. Identification of the organism will point the way for the choice of the proper drug. If it is a mixed infection, sulfonamides are preferable; if it is a colon bacillus infection, mandelic acid and ammonium chloride may be effective if the ph of the urine is kept on the acid side.

There is no specific treatment for pulmonary complications nor is there any rule of thumb method of treating "cerebral rheumatism". It should be recognized that salicylate therapy sometimes produces cerebral irritation. In the average case, digitalis is not indicated as it has very little effect and may actually favor the onset of cardiac arrhythmia. If congestive failure develops, digitalis may be tried cautiously. Electrocardiographic records may at times be a guide to the proper dosage of digitalis to be used under these circumstances.

#### BED REST

It is generally agreed that absolute rest in bed is indicated during the early and acute stage of rheumatic fever to the same degree that it is advisable in the active stage of pulmonary tuberculosis.<sup>17</sup> Just how long this rest should be continued is a question which has aroused considerable debate. Certainly no set of rules can possibly apply to all cases. E. V. Allen<sup>18</sup> maintains that there is insufficient evidence to prove that keeping patients in bed has contributed to their recovery or lessened the danger of permanent valve damage. It is a well-established fact that the venous congestion is less in patients who are permitted mild physical activity and it is not too difficult to prove that there is less load on the right heart if the legs are dependent. During the stage of acute carditis, the blood flow from the extremities can be aided by careful massage and passive motion. It seems rather risky, however, to allow a child extremely ill in the very active stage of rheumatic fever with a cardiac complication to get out of bed. That there has been some abuse of absolute bed rest becomes more evident each year. Active children who show signs of convalescence, whose nutrition improves, whose temperature is normal and pulse not too rapid, whose white blood count, sedimentation rate and electrocardiogram are normal

may be allowed to sit in a chair at the side of the bed and have a few privileges about the bedroom. Those who have worked in convalescent homes for cardiac children feel strongly that the more rest the better. They are certain that the cardiac complications are less severe if a strict regimen of rest is followed. It seems wise to keep children at almost complete rest until there are no longer signs of rheumatic activity.

There is some difference of opinion on this point but most students of the subject agree that some of the following signs, alone or in combination, may be used as an index to the recognition of continued rheumatic inflammatory reaction within the heart:

(a) Persistence of elevated temperature (100 degrees or more); (b) increased pulse rate (100 or higher); (c) elevated white blood count; (d) increased sedimentation rate; (e) electrocardiographic evidence of delay in conduction between auricle and ventricle; (f) gallop rhythm or other irregularity; (g) persistence of nodules or nodes; (h) failure to gain weight and strength—other causes eliminated; (i) joint and muscle pains; (j) swollen inflamed lymphoid tissue in throat; (k) persistent anemia; (l) various erythemas.<sup>19</sup>

Some of these signs are variable. For instance, the white blood count may be normal for a week or so then may show a rise. The electrocardiographic changes may be present for a time, disappear only to reappear without any other sign of inflammatory reaction. The physicians in the armed forces are placing great dependence on the persistence of high sedimentation rate as evidence that the rheumatic infection is in the active rather than the latent stage.

The tendency for rheumatic fever to recur is well known. There is ample proof that the recurrences are less likely in warm climates. Therefore, whenever possible, patients who are in the latent stage of the disease should spend at least the first winter following an acute attack in the South and should live the rest of their lives in a warm climate if this can be arranged. Lacking this opportunity, a great deal can be done to keep such patients from having a recurrence by strict attention to the hygiene of life. Warm clothing, avoidance of wettings, chilling, avoidance of public functions, and fatigue are important considerations. Daily use of the ultra violet lamp has been helpful in our experience. If infections of any kind are contracted, the patient should be given special care with bed rest and a prolonged convalescent period. In this state, the public school system has arranged a method of tutoring which permits children to keep up with their classes at home or in special schools where they may have extra nourishment and rest periods in the middle of the day. Youngsters who have a tendency to be very active

physically may do well in a special hospital for the treatment of cardiac children.

#### TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS

There are few fields in medicine where more progress has been made than in the treatment of subacute bacterial endocarditis. In the first place, exact diagnosis is more often made than formerly. The realization of the fact that those who have had previous attacks of rheumatic fever are likely to develop this condition is generally accepted and when such patients have an unexplained fever, blood cultures are promptly taken and a careful search for petechiae and Osler's nodes is made. Once the diagnosis is established, intensive treatment is begun. Penicillin has proved to be a cure in about 40 per cent of the cases if given in large enough doses and over a long enough period. It is important to give large doses when treatment is first instituted, preferably by intravenous continuous drip, 200,000 to 300,000 Oxford units per day in normal saline solution. This can be followed by intramuscular injections every three hours, 30,000 units (240,000 units per day), for four weeks.

Some strains of streptococci are resistant to penicillin and the failures which have been reported have come about for this reason or because the treatment was discontinued as soon as the temperature came to normal. Very often the blood stream becomes sterile after 24 to 48 hours of treatment, but it is quite certain that the lesions in the valve leaflets are not sterilized this quickly. In several of the reported cases, two or more courses of penicillin over a period of 3-6 months<sup>20</sup> have been necessary to bring about a cure. It is not possible at this time to evaluate properly the treatment of subacute bacterial endocarditis with penicillin. More time must elapse and more cases must be treated by various methods and concentrations of penicillin before a final answer can be made.

The sulfa drugs are effective in about 7 per cent of cases.<sup>21</sup> Two recoveries in our service were reported in 1944.<sup>22</sup> It was a great comfort to be able to tell patients that this disease which was almost 100 per cent fatal now can be successfully treated in a high percentage of instances.

#### CONCLUSION

Every patient, especially a child with a hemolytic streptococcal sore throat, is a likely candidate for rheumatic fever or rheumatic heart disease. If the history reveals a rheumatic tendency in the family, the likelihood is greater. If there has been a previous attack of rheumatic fever, the chances for original or further damage to the heart is greatly increased.

Experience in the Army and Navy Medical Services arouses hope that prophylactic meas-

ures will be effective. Selected group rather than mass attempts at prophylaxis seem best at this time. Very early diagnosis and treatment of hemolytic streptococcus infections of the nose and throat are advised. Recognition of the fact that there are many cases of rheumatic heart disease which have never had polyarthritis is essential. A thorough understanding of the fact that severe cases of heart disease may occur even after slight upper respiratory infections is essential. Very careful study of children who "drag around" for 3-4 weeks after sore throats may result in the earlier diagnosis of unexpected heart lesions.

Subacute bacterial endocarditis is successfully treated in 40-50 per cent of the cases with penicillin. Intensive therapy for at least 4 weeks is advisable even though the temperature is normal. Seven per cent recoveries from subacute bacterial endocarditis are reported when the sulfonamides are used.

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# Changing the Food Habits of Our People

MARTHA KOEHNE, B.A., M.A., PH.D.

FOOD habits have in the past been influenced greatly by religious laws and practices, as illustrated by the food customs of the Jews, Catholics, Mohammedans, etc. More recently some food customs and habits have been the result of laws passed in the interest of public health, as illustrated in our pure food laws; by new eating practices resulting from food shortages and rationing; and by new methods of processing and packaging.

Always there have been markedly different cultural patterns in the food habits of different nations and in different climatic areas. In our own country we find as wide a variety of food habits and customs as is found anywhere in the world. The southeast differs from the southwest, New England from Florida, New York from Iowa, Montana from western Washington, etc. In addition, in all these areas we have representatives of different nations and religions.

Socio-economic factors also influence food habits conspicuously. Finally, among individuals we find peculiarities of eating that result from personal reactions to psychological and emotional influences in their environment.

Parents, teachers, physicians, nurses and others are prone to think of food habits in terms of desirable change. If changes are to be accomplished one should know how closely the person or group clings to his or its own diet, how changes may be suggested so that they will be accepted, and how to avoid merely temporary compliance with, or even resistance to, change.

This discussion will not be concerned with religious, national, and geographic cultural food patterns, but will, instead, be concerned with environmental influences, chiefly emotional and psychological, which cause so many people to prefer eating as they please to eating foods which provide their bodies with the material needed for good health.

Our discussion will deal with factors influencing appetite and one's general attitude toward food and will close with a critical analysis of the various methods used by nutritionists, parents, teachers, and others who seek to improve the food habits of this generation.

I wish to express my personal appreciation for the help given me in the preparation of this

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paper in the published reports of members of the Committee on Food Habits of the National Research Council. <sup>1, 2, 3</sup>

## FACTORS INFLUENCING APPETITE

All of us, and parents in particular, should be thankful that nature endowed us with hunger pangs. Hunger pangs stimulate desire for food or appetite. Yet hunger pangs alone will not make us eat when we become conditioned against eating by unfavorable environmental conditions. When such conditions prevail we may even cease to experience the sensation of hunger. Lack of healthy appetite has been said by Dr. Aldrich<sup>4</sup> to be a disease of modern civilized children, especially those who live in homes of well-to-do intelligent parents. The same is also true of adults. What are some of the factors that stimulate appetite or that, on the other hand, make many persons disinterested in food?

First of all, eating should be a source of constant pleasure and comfort. Anything that spoils the pleasure and satisfaction of eating will lower the desire for food. We may list the following as some of the common conditions we see that make eating unpleasant:

1. Unpleasant scenes at the table.
2. Scolding or nagging a person about what and how much he eats.
3. Punishing a child just before, during, or immediately after a meal for behavior problems or poor table manners.
4. Quarreling among members of the family just before or during mealtime.
5. Forcing a child to eat food he doesn't want.
6. Serving food that is unattractive in appearance, flavor, texture, and temperature.
7. Serving food in too large portions or in unclean, unwholesome surroundings.
8. Eating when not comfortable, due to unsuitable height of chair, feet dangling in the air from lack of support for them, having to stay at the table far too long, etc.
9. Depriving young children of the fun of feed-

Presented at the Fourth Annual Conference on Conservation, Nutrition, Health, and Happiness, Athens, Ohio, on July 1, 1945.

ing themselves by spoon-feeding them too long. What if they do spill some food?

10. Probably the most important inhibitor of appetite is the overly great and outspoken zeal of well-meaning parents to get the right food down their children. I can do no better than to refer to Dr. Aldrich's excellent book for the following experience to illustrate what happens. A mother brought a very thin little boy to see Dr. Aldrich, explaining that she couldn't get him to eat. The next day the doctor dropped in at the home at dinner time. He went into the dining room and found the "poor little picked chicken of a boy eating furtively at a table with nine adults, all keeping a weather eye out for each hesitant spoonful that wavered toward his lips". Adults need to develop a casual unconcerned but positive attitude toward a child's eating habits. The whole atmosphere at the table should be one of pleasant anticipation of a good meal and of fun in eating it.

11. In homes of the well-to-do, food is sometimes too easy to get to keep children sportingly interested in food. Menus are sometimes so varied in such homes that confusion is caused in the child's mind as to what he wants to eat.

12. Other physical factors may affect appetite unfavorably, such as: Decayed teeth that hurt when one eats, or missing teeth that prevent chewing the kind of food a person prefers. Over-fatigue and constipation; colds and sore throat; and certain chronic diseases such as tuberculosis and heart disease.

#### FACTORS INFLUENCING ATTITUDES TOWARD FOOD AND NUTRITION

By a positive attitude toward food we mean open-mindedness in contrast with a negative attitude or slavish insistence on following one's own pet ideas about what to eat. If everyone had as high standards of human health and of the relation of food to health as do successful animal husbandrymen, the positive attitude would prevail instead of the negative. A farmer cannot raise livestock with maximum health characteristics unless he pays the strictest attention to what they eat.

What are some of the influences that affect unfavorably one's attitude toward food and nutrition teaching?

1. The poor example set by the eating habits of someone whom a person loves and admires.

2. Prejudices against many foods as a result of prevailing misconceptions about foods and certain combinations of foods, such as:

a. The false idea that we inherit our dislikes of food and nothing can be done about it.

b. Some believe that instinct is our safest guide in food selection, when, in fact, under conditions of modern life, instinct has practically no chance

to guide us in food choice. This reasoning is often used as a rationalization of a person's dislike for a number of common foods and has little scientific basis.

c. Another fallacy is that if one dislikes a food it should not be eaten for it will not digest. Contrast this with the fact that we like foods that we are accustomed to eat.

d. Fear of certain combinations of food, such as: (1) Eating acid-tasting food with milk, ice cream or with starchy foods; (2) eating fish or seafood with milk or ice-cream; (3) eating meat, fish or poultry with starchy food, and many other bizarre notions, none of which have the support of modern medicine.

3. Lack of understanding of so many parents of basic psychological principles underlying the formation of good food habits, as illustrated by:

a. Discussing likes and dislikes of food of various members of a family or of friends in the presence of children.

b. The very common practice of luring children to eat nutritious foods they are not particularly interested in by offering as a bribe or reward for eating them, foods they like but which are not nutritionally valuable. This practice puts all the glamor on the undesirable food and all the stigma on the nutritionally valuable food. According to Margaret Mead this is an eternally self-defeating situation as long as wrong and right foods are so frequently available at the same meal. She says we must dissociate eating habits from the moral issue or we "will never have a population which eats gaily and unquestioningly food based on the best nutritional science which we have". Children grow up feeling that eating delicious food is an indulgence and eating right foods an unpleasant chore. "Every meal becomes an experience in which an individual must decide between doing right or enjoying himself." Dr. Mead says that a successful dietitian in charge of the food for a group would never think of placing the less nutritional foods in the more attractive setting and of relying upon "sermons and texts printed on the walls, or buttons or emblems distributed to those who made nutritionally sound choices", for getting nutritionally desirable foods eaten.

c. The very common practice of asking children if they want a certain food. This practice can only start trouble by putting the idea into the child's head that maybe he should not want it and thereby give him a chance to say "NO". One of the parents should serve the plates at the table, putting on each plate what he wants the child in question to eat, with no questions asked but with the use of discretion in how much of a certain food he may expect a given child to eat.

#### HOW MAY FOOD HABITS BE CHANGED?

The nutritionist, nurse, physician or other teacher must believe enough in his own program



that he practices what he teaches. It helps a great deal if this person is the picture of health. He must also be able to convey his own enthusiasm to the person or group he wishes to help. Unless he can sell the desire to understand modern nutrition and its close relation to health to those with whom he works, he will fail no matter how much he knows about the science of nutrition. He must be consistent and practical in his teaching and, of course, truthful. He must understand the social and economic background of those with whom he works. He must never be afraid to say he does not know the answer to a given question, but must be willing to find it out.

We have already discussed the fallacy of using the moral issue as a basis for changing a person's food habits.

People are ready for changes in food habits as their social status changes either for better or for worse. If we can reach them at the right time, we may be able to direct the changes into desirable channels, provided we use the right approach. I understand that the Labor Unions are reaching the stage now at which they will soon undertake responsibility for seeing that their members receive instruction in food selection and food for their families. This is a very wholesome sign.

We are living in a period now when our food habits are changing markedly because of food shortages and rationing. Such a situation offers an excellent opportunity to teach people the value of alternates for scarce foods and how to use them, so that they will not regard the present situation merely as one of privation. We want them to see it as a chance to learn the use of a wider variety of foods and new ways to use plentiful foods to keep meals interesting.

We must develop positive methods of approach in our field of education of the general public that will convince our public that they need to keep up to date in their eating habits just as they do in methods of farming, of running their businesses, in methods of disease prevention and treatment, in their plumbing, heating and lighting, in labor-saving devices they use, in their hats, clothes, etc. To illustrate, many of the younger generation of Jews are convinced that modern science is now a better protection to their health than is the old Mosaic Laws pertaining to food and sanitation. Using modern laws of living does not, however, make them less loyal to their religion.

No one today wants to be behind the times. With science bringing us day by day new information and new tools with which to work or play, why shouldn't people be willing to change their ideas about food as well? There should be as much stigma attached to clinging to old ideas about foods as to old style hats and dresses. We have a much better chance to influence young

people with this approach than by begging them to eat something because it is "good for them".

Through properly managed school lunchrooms and industrial lunchrooms, we have a chance to show people that the right kind of food can be even more fun to eat than the wrong kind. We will never be able to get everyone to like vegetables until we modernize the ways they are prepared and served in many homes and public eating places. Speak of this as modernization rather than as reformation!

I read a report from Norway recently to the effect that the only good effect of the German occupation was the fact that the teeth of the general population were in good condition due in large part to the almost complete absence of sugar from their diet for the past three or four years! Maybe if our sugar shortages continue we will see the same result, though on perhaps a less convincing scale than was observed in Norway. If this happens, perhaps we can then convince parents not to feel that they are being cruel to their children if they do not permit them to have candy. Maybe then we can convince them of the wisdom of the Council on Food and Nutrition of the American Medical Association when they recommended several years ago that the use of sugar be restricted to making highly nutritious foods more palatable.

#### WHAT ARE SOME OF THE METHODS THAT HAVE BEEN FOUND SUCCESSFUL IN MODIFYING FOOD HABITS?

##### A. Indirect Methods of Approach in Teaching Good Nutrition:

1. Communal feeding programs as illustrated by:

a. The so-called British restaurants which have offered in wartime to anyone a well-balanced and carefully planned meal at minimum cost and free of ration points. At these restaurants people could also buy prepared food to take home to eat.

b. Our federally subsidized school lunch and nursery school feeding programs.

c. We may also include the food service in many of our war industries where the management provides excellent meals at minimum cost.

d. The feeding program for our armed forces. Every effort has been made to provide our armed forces with the best possible food, in meals as carefully planned as conditions of combat and the location of the forces permit. Even the combat rations, such as the well-known K ration, have been planned with the utmost care and research, with the nutritional well-being of the soldier in mind as well as the ability of the ration to satisfy hunger and give the maximum possible satisfaction to the one eating it.

It is hoped that all these efforts in mass feed-

ing of carefully planned meals will have a marked influence for the good on the food habits of our people. Although our returning soldiers may have individual unfavorable reactions to certain items of food that may have made their food monotonous at times, especially in active combat areas, nevertheless, these men cannot help but realize how their food has contributed to their health. British restaurants have had a remarkable influence on the health and food habits of the masses in the British Isles. Many observations have been published of the good influence of carefully planned school lunches and meals served in industrial plants on the health and efficiency of those who eat them regularly and of carry-over into the home of this indirect type of teaching.

2. Distribution of highly nutritious foods at reduced cost to low income families such as was done under the Stamp Plan and which may be resumed in the postwar period under a broader but more carefully thought out plan. This method is especially good if, throughout the country, community demonstrations are conducted on how to store, prepare and serve such foods in the home, and efforts are made to develop the right attitude on the part of the people affected by such a program.

#### B. Direct Teaching Methods:

1. Continuance and strengthening of county nutrition committees, probably as an integral part of a broader county-wide organization of health, welfare, education or agricultural agencies. Such a nutrition committee or sub-committee can work in the closest cooperation with the state nutrition committee. Communities should provide financial support to the work of county nutrition committees, if they are to do effective work.

2. State nutrition committees should correlate the nutrition programs of federal and state governmental agencies, and of state professional, trade, and lay groups, directing their efforts along lines that seem best adapted to bring desired results.

3. Stimulate the wider production and more even distribution of especially valuable foods; improve our methods of food preparation and preservation, particularly those used in homes.

4. Discourage in subtle ways the use of foods commonly used that are low in nutritive value, even though high in taste appeal, instead of encouraging their use by offering them as special rewards.

5. Put at least equal emphasis in nutrition teaching on developing right attitudes toward food and on maintenance of conditions conducive to good appetite as we have been placing on what to eat and how to prepare it. Many parents are pitifully unable to raise children with normal

healthy appetites who are really interested in eating their meals.

6. Develop the same attitude toward changes in food habits as the great mass of our people now have toward changes in styles of hats, hair dresses, clothes, cars, running their businesses, etc.

7. Present nutrition as an ever important factor in good health and efficiency, not just as a problem of temporary war interest.

8. Teach nutrition flexibly, using the seven basic food groups to show how substitutions for scarce foods can be made safely. If dealing with foreign-born groups, study their own food habits first and adapt your teaching to that background, showing good points and how to correct weaknesses.

9. Whenever possible a good demonstration should be a basic part of every lesson in foods that we teach.

#### C. Media Available Today for Getting Nutrition Information to the Masses of Our People:

1. Radio offers an excellent medium provided the information is presented in a manner that will hold the interest of the listener. Panel discussions on the radio or dramatized skits, such as are available through the War Food Administration's "Food Makes the Difference" weekly series, have been successful, especially if given at regular times so that the housewife knows when to tune in.

2. Moving pictures provide an excellent medium for mass education in foods and nutrition. However, we need more and better ones in this field and we need to discard those in which the actors are dressed in old-fashioned clothes, for such pictures, no matter how good the lesson is, merely bring laughs from the audience. Having seen the fine new films by Walt Disney "Defense Against Invasion" on immunization and "Winged Scourge" on malaria control, I am very hopeful of the success of his newest one "Something You Didn't Eat" which will be shown in the theaters this Summer and which will be available in 16-mm. size by September.

3. Newspaper articles are usually widely read in rural areas. County nutrition committees can offer better service along these lines than can syndicated articles, for they can adapt their articles to current problems in the community served by the paper. Such committees can secure valuable help in the preparation of such copy from the War Food Administration's weekly series "Food for Folks".

4. Magazine articles have been excellent and color illustrations of recipes have been most helpful in reaching their subscribers and readers.

5. Many food processors or national organizations of food processors have spent money lav-



ishly in preparation and wide distribution of highly educational leaflets, pamphlets and posters.

6. State and federal agencies also provide educational material and personnel for educational programs in nutrition designed to reach the general public and food service organizations.

#### SUMMARY

It has been said<sup>5</sup> that there are three important tasks ahead of us: Application of existing knowledge in a discriminating and active program of nutrition education; seeking out and developing channels for reaching those in greatest need of help; further research in what should be taught, methods for presenting information on foods and nutrition most effectively, and effects of good nutrition on improving health and productive efficiency.

Today it is true, as never before, that if we can stimulate the people living in various communities with the desire to eat the right kind of food, there is ample opportunity to secure reliable information. If a person wants to know and succeeds in getting the information he needs, he can be depended upon to apply this information in his everyday life. The trouble is we have been spending too much time in the past giving out information and not enough time in arousing real interest in the relation of food and food habits to the development of our bodies and our health and to the improvement of human efficiency.

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The rheumatic fever rate will surely decrease substantially and effectively if a community can manage to provide better socio-economic conditions for its citizens through improved housing and an opportunity for more healthful outdoor activities; less crowding and an intelligent consciousness of good nutrition; good public health control of communicable disease, particularly streptococcal respiratory colds and sore throats, with facilities for careful examination of children suspected of having rheumatic fever. This has been accomplished to a great degree in the case of tuberculosis control, and a more thorough application of these principles will reduce further the tuberculosis rate as well as the rheumatic fever rate.—Hugh McCulloch, M.D., *Minn. Med.*, Dec., 1944.

## KEEPING UP WITH MEDICINE

THIS war has shown us that money in the pocket does not always mean the correct food in the child's stomach. It also requires the intelligent use of correct information.

\* \* \*

MORE people in this country are suffering from arthritis or some rheumatic manifestation than the sum of all of the individuals who are affected with cancer, tuberculosis, diabetes, and heart disease.

\* \* \*

WE are hearing much of the medical care plans for the employees (only) in ship-building yards and other war plants. But isn't it strange that those most widely publicized lack the basic principle of preventive medicine. They only care for the sick worker, himself, and offer nothing in the way of periodic systematic examination.

\* \* \*

ACCORDING to government experts the cost of a rat ration is about one-half a cent a day, making the total cost of feeding the rats in this United States, \$8,000,000.

\* \* \*

IF at forty we are forced to adjust ourselves to the involuntary changes which usually begin about then, it is important to evaluate ourselves so that on self-analysis our character and philosophy is one with which we are content. While estrogenic substances and male hormone may be important, the development of a hobby, a sense of humor, spending more time with others and learning that the utmost in human satisfaction comes from helping or doing things for others, these things make a better prescription than endocrines in the average case.

\* \* \*

OLD people ought to be given more of a chance to stay on the job. This retirement business is a soft way of killing our grandparents. Over the years we accumulate wisdom as the result of experience. We have more self-control and make fewer mistakes due to haste and impulsiveness.

\* \* \*

ASTHMA contributes not only to the frequency of the formation of hernia, but also to its recurrence after surgical repair.

\* \* \*

BRONCHIAL adenoma is not an uncommon cause of bronchial obstruction. Suspect its presence with recurring symptoms and signs of bronchial obstruction in young or middle-aged women.

\* \* \*

ENDOCRINE deficiencies are of more importance in habitual abortion than is the Rh factor.—J. F.

# Coach Leg

PAUL S. ROSS, M.D., and ALEXANDER P. ORMOND, M.D.

THE purpose of this communication is to call attention to a type of edema of the lower extremities frequently seen after long rides in train coaches without sleeper accommodations. This condition is characterized by swelling with edema, and frequently with congestion of the soft tissues of one or both, usually both ankles. The authors have studied 12 of these cases in detail and have seen many similar cases, both at this and other Army Bases, and have been informed of many similar observations of unexplained edema by other Army physicians. All of the soldiers studied were sent into the hospital either because they complained of redness, swelling and aching of the ankles, or because the presence of edema was discovered during initial physical examinations on arrival at the Bases.

## HISTORY

The history usually shows that after the soldier has been constantly on the train for at least 24 hours, he notices swelling of the feet and ankles, accompanied by discomfort of varying degree, from mild to moderate, but never severe. The tissues about the inner malleoli are most severely affected. True pitting edema usually is present. There is associated aching and tenderness of the superficial tissues, and frequently there is localized heat and rubor. The pitting edema may be masked by congestion, and may not be well demonstrated until the hyperemia subsides. Congestion at times is so marked that it may be the presenting symptom and the feature which both alarms the patient and deceives the physician.

This condition superficially may resemble arthritis, but there is practically no tenderness of the joint on the passive motion, nor is there pain on the anvil test. There is no evidence of involvement of the joint surfaces nor of the deep periarticular tissues. In spite of the localized heat and redness, there is no evidence of real bacterial inflammation as shown by the temperature, leukocyte count, and sedimentation rate. These are uniformly normal.

There is a complete lack of abnormal laboratory findings: serum protein and albumen-globulin ratios are within normal limits and blood chlorides are normal. Urinalyses, renal concentration tests and blood chemistry show no evidence of nephritis. No abnormality of the cardiovascular system can be found. There is no evidence of lymphagitis, lymphadenitis, ve-

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nous obstruction or vascular disease in the legs, and the soldiers did not wear garters. Roentgenograms of the ankles have been entirely normal. Rapid subsidence of all symptoms and signs occurs within 24 to 72 hours with no other treatment than the recumbent position with short intervals of mild muscular activity.

This condition appears to be true lymphedema secondary to muscular inactivity and the dependent position of the limbs over periods of time in excess of 24 hours. None of these soldiers had assumed the recumbent position during the train rides. All of them had long periods of enforced muscular inactivity. Sometimes they were traveling under unusually hot conditions and had consumed excessive fluids. However, the heat and the increased fluid intake were not characteristic of all cases seen. Nor were they traveling under similar conditions of altitude and weather.

## CASE REPORTS

The following case reports illustrate the usual diagnostic features:

Case 1. A 21 year old white male entered the hospital July 21, 1944, complaining of swelling of the ankles. He had left California July 4, 1944, on furlough to his home in Virginia. He took a coach with no sleeper accommodations. At the end of the second day he noticed redness and swelling on the inner aspect of both ankles, worse on the right. There was some dull aching over the swollen area and over the lower calf muscles. Walking created sharp twinges but no acute pain about the ankles. He was on the train four days and his feet were swollen badly when he arrived home. He drank much water and perspired moderately as the train was quite hot. He drank six or eight bottles of beer on the trip but no other liquor. With no treatment the swelling disappeared 48 hours after getting home. He stayed home seven days, during which time he had no trouble with his ankles.

On the return trip to his camp the swelling recurred after two days on the train. Traveling



was very cramped on the way back—three men were assigned to one seat and one man had to stand part of the way. He had no alcoholic drinks of any kind on this trip. He lost much sleep and was very tired. He continued to eat and drink normally. He did not perspire much on the return trip. Aside from discomfort in legs and feet he felt fairly well. He was admitted to this hospital after four days on the train.

Physical examination showed pitting edema of both ankles. The skin over the inner aspect of both ankles was tense, overlying obviously swollen tissue approximately 5 inches in diameter, extending toward the instep and up the leg about 4 inches. The skin at the center of this swollen area was dusky red and there was a small ecchymotic spot at the proximal edge of the swelling on the right ankle. There was localized increase in temperature over the reddened part of the right angle. The dorsalis pedis and posterior tibial arteries were palpable on both ankles. There was no evidence of phlebitis, angitis or lymphatic streaking. The heart was normal. The pelvic area was not tender. There was no true limitation of motion of the joints. The hammer and anvil test was negative. The muscles of the calves were slightly tender to pressure. There were no paresthesias nor reflex changes.

Laboratory examinations: Blood count showed Hb 100 per cent; RBC 4,810,000; WBC 11,000; polymorphonuclear cells, 71 per cent; sedimentation rate 2 mm. per hr.; blood chlorides 454 mgm. per cent. The serum albumen and globulin were normal on admission and four days later.

The patient presented no fever while in the hospital. On bed rest with mild occasional exercise the congestion and edema completely subsided within 24 hours.

Case 2. Age 28. The soldier had been traveling from Massachusetts to California by coach and developed swelling and pain in both ankles after 72 hours on the train. He did not recall injuring the ankles recently, although he had sprained the left ankle twice during the past seven years.

On admission to the hospital the left ankle was found to be markedly swollen, red and tender, the right ankle slightly so. There was no fever. There was a questionable soft systolic murmur at the apex. The impression of the admitting officer was acute rheumatic fever. The next day the right ankle was found to be slightly swollen and tender, the left ankle markedly so. The swelling and inflammation was confined to the superficial tissues. True pitting edema was demonstrated on the third day of hospitalization after the congestion subsided. The blood count showed Hb 85 per cent; RBC 4,820,000; WBC 78,000; polymorphonuclear cells 73 per cent; lymphocytes, 22 per cent; large monocytes, 3 per cent. The Westergren sedimentation rate was 3 mm. in 1 hour. The systolic murmur which had been heard by the admitting officer could not be found. At no time during further hospitalization was the murmur heard. All other tests and laboratory findings were normal. At no time did the patient have any fever.

This patient had been started on salicylates on admission because of the possibility of rheumatic fever. However, as soon as observation and laboratory tests failed to confirm the presence of any infectious process, the salicylates were stopped. Recovery was rapid with bed rest and short intervals of exercise.

## DISCUSSION

It is of interest to note that this case, as other cases we have seen, can be confused with acute inflammatory conditions such as acute arthritis of rheumatic fever. The role of the previous injuries to the most affected ankle is of possible etiological significance.

The lymphatic system is unable to cope with the two factors of prolonged inactivity and dependency, since lymph flow is largely the result of the massaging action of muscular activity. Venous stasis is believed to have little part in the production of lymphedema as there is no direct communication between the circulation of blood and lymph. The dependent position of the leg further favors lymph stasis because the knee is bent and the posterior one-half of the leg presses on the edge of the coach seat. The lymph vessels, being largely superficial, therefore are compressed in one-half of the circumference of the leg.

Rubor, which sometimes is present in the edematous tissue, might be explained on the basis of local congestion secondary to the compression effect of the lymphedema. While there is no definite evidence that paralysis of the sympathetic vasomotor fibers plays any role in the production of the hyperemia, nevertheless it is possible that pressure of the lymphedema upon these nerve elements and local tissue anoxia due to the edema may result in some localized vasodilation. It is noteworthy also that this edema offers admirable opportunity for infection following relatively slight trauma. In older people it is likely that venous stasis plays a larger role in the production of swelling of the legs following inactivity and dependency, but the cases under consideration all occurred in young active males.

This non-infectious congestion and lymphostatic edema is not likely to be confused with other diseases once it is seen and a careful history is taken. Pathological states most likely to be confused with it are cellulitis, the arthritis of rheumatic fever, early dermatitis, rheumatoid arthritis, erysipelas, cardiac and nephritic edema. Also to be considered but less likely to be confused are lymphangitis, local injury, dermatomyositis, thrombophlebitis, thrombo-angiitis, tenosynovitis, myxedema, edema secondary to hypoproteinemia from starvation, liver or kidney disease, filariasis, elephantiasis, intermittent hydrarthrosis, true bacterial arthritides, and varicose veins.

In view of the completeness of the clinical picture, the consistency of the history, the ease with which it may be and has been confused with true inflammation and edema of other types, and the speed of cure, it is considered appropriate to give this condition a descriptive term such as "Coach Leg".



# Unusual Leg Ulcer With Diphtheroids

H. R. HATHAWAY, M.D.

**M**R. A.B.G., a short, obese, white male, age 61 was seen for the first time in 1942 with an acute gastroenteritis. There were areas of yellowish-brown pigmentation over the lower thirds of both legs and several small varicose veins in the left leg. The feet were cold with palpable normal dorsalis paedi arteries. At this time the blood pressure was 154/80 but the patient gave a history of having had hypertension since 1934. Subsequent examinations revealed blood pressures ranging from 205/145 to 250/160. He also stated that he had been smoking about two-thirds of a pack of cigarettes per day as well as drinking two or three ounces of whiskey per day for many years.

In January, 1943, following trauma with abrasions to the left leg, the patient developed leg ulcers  $1\frac{1}{2} \times 2$  and 3 inches. With the use of 1 per cent gentian violet locally, Ace bandages and rest, these were partially healed by February. From February 11 to March 25 patient received eight injections of sodium morrhuate in the varicose veins and the leg was healed by April 19, 1943.

On November 2, 1943, Mr. G. fractured his left ankle with consequent swelling, ecchymosis and formation of petechiae and bullae on the left ankle necessitating care in an open splint. A solution of 1 per cent aqueous gentian violet was applied to the superficial ulcers which crusted and healed slowly.

Patient had a severe hemorrhage from a duodenal ulcer on January 5, 1944. Sippy routine with multicebrin, ferrous sulphate and three transfusions resulted in a gradual improvement with hemoglobin rising to 78 per cent and RBC to 4,420,000.

On March 14, 1944, patient developed swelling of both legs and crusted ulcers but no evidence of varicose veins. He was advised to have four infected teeth extracted and was put on a low salt diet with fluids restricted to 1000 cc. daily. At bedtime on April 11 he complained of stabbing pain in the posterior aspect of his right leg. There was no swelling but large, firm crusts were evident on both legs. The four infected teeth were removed on April 18.

On May 2 patient complained of pain in his right heel with slight muscle spasm of the right calf. Fourteen days later he again had pain in the right ankle which lasted for two days and was accompanied by painful pink area over the inner aspect. This was treated with Searles Tetra-thione, giving one ampule intravenously on May 16 and 18.

A thick, bluish-purple crust  $1 \times 1\frac{1}{2}$  inches was removed from the right Achilles region revealing a small amount of foul-smelling, greenish-yellow fluid. Upon removal of this there was found a shallow base covered by exudate of similar color. Dressings of 1 per cent Dakins solution were applied.

The patient was admitted to Lakewood Hospital on May 25, 1944, when it was found that the ulcer appeared to be getting larger and a smaller one was found on the lateral aspect. Laboratory studies were reported as follows: Cell

## The Author

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volume 41 per cent, sedimentation rate 7 mm. in half hour, 25mm. in an hour; urine amber, acid, specific gravity 1.025, albumin negative, sugar negative; blood sugar 90; coagulase test positive in 40 minutes; Kline negative; anaerobic and aerobic cultures from the ulcer showed only *Staphylococcus albus*. In spite of temporary minor improvement under the therapy outlined below, the ulcer spread gradually until it involved two-thirds of the lower half of the leg, as shown in Figure No. 1, and pain was severe enough to warrant the use of codeine and morphine daily.

From May 27 to May 30 the ulcer was treated with zinc peroxide according to the Meleny therapy. From May 30 to June 5 10,000 units of penicillin were given Q 4 H, intramuscularly, and applied locally 250 units per cc. in normal saline. From June 5 to 8 intramuscular injections were reduced to b.i.d. On June 8 red streaks appeared in the upper leg and thrombosed veins were palpable. Compresses of 50 per cent Epsom salts solution were used up to the knee with 1 per cent Dakins applied to the ulcer. Sulfadiazine grams 2 were given Stat., then grams 1 Q 4 H for 48 hours, then q.i.d. The reddened areas in the skin disappeared in three days.

A specialist in peripheral vascular disease saw the patient in consultation on June 11 and believed the ulcer was due to anaerobic bacterial infection and that no real vascular disease was present. Zinc peroxide was used again and the sulfadiazine discontinued on June 16. Two days later the ulcer appeared larger so penicillin in 10,000 units Q 4 H was prescribed again, the dosage being increased to 15,000 units Q 3 H on the next day. The zinc peroxide was continued.

A gastrointestinal series of roentgenogram done on June 23 showed evidence of healing of the duodenal ulcer.

After consultation with a specialist in internal medicine on June 26 the therapy was changed to exposure of the ulcerated area to direct sunlight for five minutes daily, Burrow's bichloride compresses, Fortified C.L.O. locally and liver extract and B complex intramuscularly.

On June 30 the discharge from the ulcer became bluish-green, typical of *Bacillus pyocyaneus* infection and compresses were changed to 5 per cent acetic acid. Because of painful reaction to sunlight, exposure was discontinued on July 3. At this time a culture was reported to show *B. coli* and *Staphylococcus albus*; smear showed occasional leukocytes, moderate number gram-positive cocci, gram negative bacilli and occasional gram-positive diplococci. On July 4 the penicillin was discontinued. Pain recurred on July 6, discharge increased and Tyrothricin was





Figure No. 1

used locally in compresses. This was changed to Aloe Vera leaves used locally on July 12. Dr. H. K. Giffen, pathologist at Lakewood Hospital, saw this patient in consultation on July 14 and suggested a culture for diphtheria bacilli. This was done and almost a pure culture of diphtheria-like organisms was found. The patient was then given 40,000 units of diphtheria anti-toxin intramuscularly and ointment of nupercain saturated with aqueous merthiolate was applied locally to control pain.

Dressings were changed to normal saline on July 22 and two days later biopsies were taken which showed only focal suppuration of the skin with acute and chronic inflammation.

Definite improvement was noticed on July 29 with epithelization of the borders. However, a smaller ulcer was beginning on the lateral malleolus. The patient was allowed to go home and instructed to use 10 per cent boric acid ointment locally. The larger ulcer healed gradually but the one on the lateral malleolus increased to 2 inches in diameter and  $\frac{3}{8}$  inch in depth. On August 29 10,000 units of diphtheria anti-toxin were injected in the skin around the lateral ulcer which healed spontaneously by September 20. Pinch skin grafts were then applied to the larger ulcer. Complete healing of both ulcers had taken place by October 31, 1944, as shown in Figure No. 2, and there has been no recurrence except



Figure No. 2

for a few small vesicles which healed spontaneously.

About November 27 patient developed a cold, blue discoloration of the left foot with a small thrombosed vessel at the base of the left great toe nail. This healed spontaneously in a few days.

#### CONCLUSIONS

This obese white male, age 61, a known chronic alcoholic, with probable diffuse arterial and arteriolar sclerosis, hypertension, infected teeth and a healing peptic ulcer developed a chronic leg ulcer which resisted many kinds of therapy. Injection of diphtheria anti-toxin was followed by rapid and thus far permanent healing.

The purpose in reporting this case is the hope that it may stimulate others to look for diphtheria-like organisms in chronic leg ulcers of doubtful origin. It is necessary to make cultures on Loeffler's blood-agar media if these are to be found.

#### DISCUSSION

Dr. H. K. Giffen: The striking feature of this ulcerative lesion was a brilliant red, acutely inflamed ulcer with very marked pain which seemed out of proportion to the duration of the ulcer. Clinically, the ulcer and story remind me of the so-called "Veld sores" which are seen in tropical countries. They were reported first from Egypt where they were common in the present and the previous World War. These respond readily to diphtheria anti-toxin. In them the diphtheria organisms have been repeatedly isolated and proved as the cause.

# Bilateral Recurrent Laryngeal Paralysis (Bilateral Abductor Paralysis)

JULIUS W. McCALL, M.D.

**B**ILATERAL recurrent laryngeal paralysis clinically known as bilateral abductor paralysis, is seen most often after thyroidectomy. The next most frequent cause is cerebral lues.

In doing a thyroidectomy, the recurrent laryngeal nerves may be severed at operation, or they may be so constricted by scar tissue as to cease to function. In considering the anatomical relationship of the recurrent laryngeal nerve, and the thyroid gland, it is readily seen how easy it is to injure one or both nerves in doing a thyroidectomy.

## ANATOMY

The left recurrent laryngeal nerve springs from the vagus where the latter crosses the left side of the aortic arch. It then passes below the arch and upon its right or medial side to gain the interval between the trachea and esophagus. The right recurrent laryngeal nerve leaves the vagus and winds tightly below and behind the subclavian artery and gains the interval between the trachea and esophagus on the right side of the neck.

The recurrent laryngeal nerves are (a) between branches of the inferior thyroid artery in 65 out of 98 cases, (b) entirely anterior in 8, (c) entirely posterior in 25.

## PATHOLOGY

The recurrent laryngeal nerves supply the intrinsic muscles of the larynx. Paralysis of the nerve causes paralysis of the vocal cord of the same side. When both recurrent laryngeal nerves are paralyzed the vocal cords assume the median or cadaveric position, thus closing the glottis. The paired posterior crico-arytenoids are the only adductor muscles of the larynx and as they are supplied by the recurrent laryngeal nerves when they are paralyzed, it is impossible to open the glottis on inspiration. As the paralyzed cords can not open the glottis on inspiration, the flaccid cords are drawn closer together, by the inspired current of air, causing the inspiratory crowing sound which is typical of bilateral abductor paralysis.

Thus, it is an inspiratory dyspnea. The patient has no difficulty with expiration as the forces of the current of air is strong enough to separate the flaccid cords wide enough to expel the air.

Contrary to general belief, there is little voice

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change in bilateral abductor paralysis. There is not as much voice alteration in bilateral vocal cord paralysis as in unilateral paralysis, because in bilateral paralysis, the cords assume the median position.

## TREATMENT

If the dyspnea comes on during, or immediately after, thyroidectomy, a bronchoscope should be introduced and a tracheotomy done with the bronchoscope in situ.

After the tracheotomy is done, it is good surgical practice to leave the tracheotomy tube in; to wait a period of six months to see if there will be a return of function of the paralyzed laryngeal nerves. If at the end of this period the patient objects to the tracheotomy tube (they usually do) and indirect or direct laryngoscopy shows no movement of the cords, the following procedure may be done.

## PROCEDURE

The operation should be done by a two-man team. One of them should be a trained laryngologist, familiar with the use of the laryngoscope and direct intralaryngeal manipulation. In any extralaryngeal operation for relief of bilateral abductor paralysis, the identification and fixation of the arytenoid cartilage is the alpha and omega of the procedure. Anyone who has done this operation realizes the greatly varying relationship between the arytenoid cartilage and the outer surface of the thyroid alae in different larynges.

Just where to make the window in the thyroid alae to expose the arytenoid cartilage is not easy. Our most common error was to make the window either inferior or anterior to the arytenoid carti-



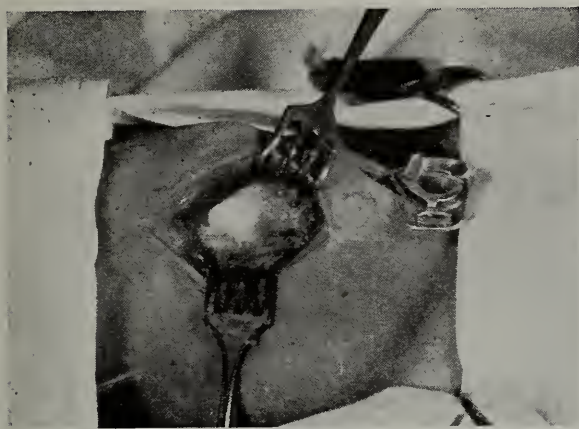


Figure I. Right thyroid alae exposed.



Figure II. Transillumination, right arytenoid through thyroid alae, using anterior commissure scope (time exposure).

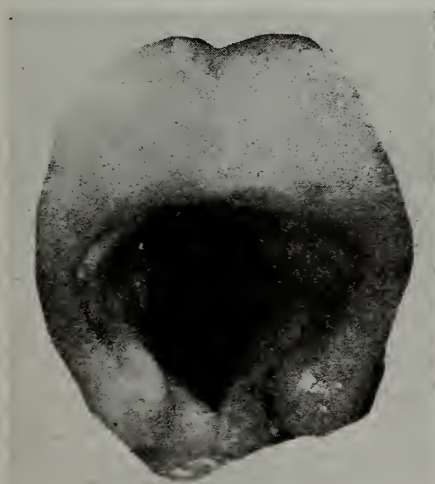


Figure III. Showing skin clip fixed in arytenoid cartilage.

lage. To overcome this uncertainty we have used the following procedure:

As soon as we have exposed the thyroid alae, a laryngoscope, or, better still, an anterior commissure scope with a bright light is introduced in the usual manner. It is important to have the largest and brightest lamp the scope will carry with the battery turned on as high as the lamp will permit. The arytenoid is then engaged by



Figure IV. Arytenoid mobilized interarytenoid muscle severed.



Figure V. Traction on suture delivering arytenoid cartilage into window of thyroid cartilage.

the end of the laryngoscope and firmly pressed laterally against the thyroid alae. The room is then darkened, and it is an easy matter to see just where the window in the thyroid alae should be made. In reality, it is a transillumination of the arytenoid cartilage through the thyroid alae.

The next most difficult step is fixation and presentation of the arytenoid cartilage through the window.

After the window is made in the thyroid alae, the laryngoscope is reintroduced in the larynx. A small full-curved atraumatic needle or small skin clip with suture firmly tied in the center is fixed in the anterior portion of the arytenoid cartilage at the cord attachment. The interarytenoid muscle is then severed and the arytenoid cartilage is mobilized by disarticulating it from the cricoid cartilage. The end of the suture is then fed through the window and traction on the suture delivers the arytenoid cartilage into the window. After the arytenoid cartilage is delivered into the window of the thyroid alae, it should be anchored securely with 0.1 chromic gut.

1. The method described is simple and time-saving.

2. It eliminates the necessity for arytenoidectomy.

# Effects of Encephalitis Occurring During Childhood on Behavior and Personality

## A Study of Fifty Cases\*

J. V. GREENEBAUM, M.D., L. A. LURIE, M.D., B. LEICHTENTRITT, M.D.,  
AND FLORENCE M. ROSENTHAL

THE following is a report of observations made on 50 children who were referred to the Child Guidance Home because of behavior disorders and personality difficulties which were found to be causally related to a previous attack of encephalitis. The thorough follow-up system of this institution has made it possible to obtain information regarding the present status of this group of patients, most of whom are now adults and some late adolescents.

Most of the authors who have reported series of follow-up cases have been concerned with all the possible sequelae of encephalitis and not merely with the effects of the disease on the behavior and personality.

Some of these reports include adults as well as children. Thus C. E. Gibbs<sup>1</sup> in 1930 reported a series of 114 cases. This was soon followed by a similar follow-up report of 85 cases in 1935 by Bond and Smith.<sup>2</sup> In 1940 Holt<sup>3</sup> presented an excellent follow-up of 262 cases. In the same year Heersema<sup>4</sup> made a report of 40 cases of a series of 51 cases which had originally been reported by Kennedy<sup>5</sup> in 1934. More recent reports are those of Litvak<sup>6</sup> and Reisman and Rose.<sup>7</sup> The cases in our series were followed for periods ranging from 3 to 25 years, the majority having been followed for more than 15 years.

### THE DATA

Due to the limitations prescribed by the editors it will be necessary to present the data in tabular and graphic form with brief comments.

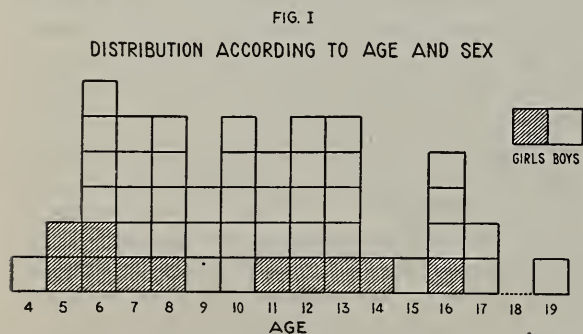


Figure I represents the distribution according to age and sex. From this graph it will be seen that there are 39 boys and 11 girls in this series

\*From the Child Guidance Home of the Jewish Hospital, Cincinnati, Ohio. Submitted June 30, 1945.

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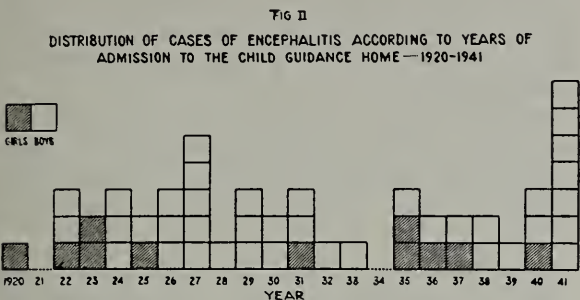
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and their ages range from 4 to 19 years. The ratio of boys to girls studied at the Child Guidance Home has been in the proportion of 2 to 1. This covers more than 3,000 cases. In this series the ratio is almost  $3\frac{1}{2}$  to 1. This agrees with the findings of other investigators<sup>2,8</sup>, namely that boys appear to be more apt to show post-



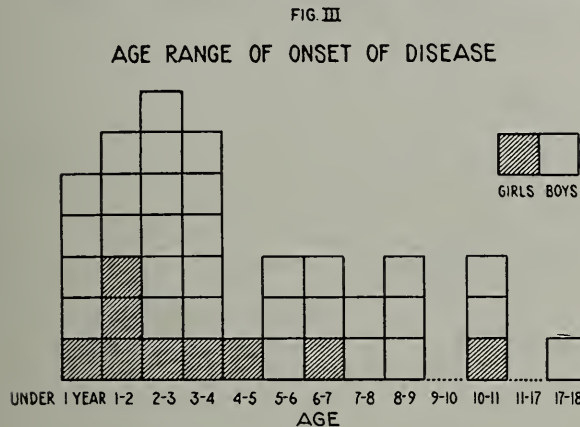
encephalitic type of behavior and personality changes.

According to Figure II, the cases from the standpoint of year of referral, group themselves



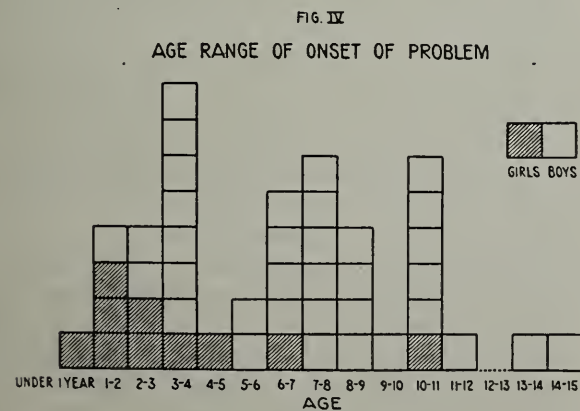
into two periods: (1) 1922-1927, and (2) 1935-1941. In the former period there were 18 cases and in the latter 20 cases.

In Figure III, the distribution of the cases according to age is shown. The exact age of onset



of the disease was unknown in 10 cases. Fifty per cent of the known cases are in the age range of 5 months to 5 years. The remainder are scattered over the remaining 14 years.

Figure IV gives the age range of onset of the behavior difficulty or personality change. Again the bulk of the cases (18) falls in the years up



to 5. There is also a large secondary group consisting of 17 cases in the age range of 6 to 9 years. The age of onset of the problem was not learned in 5 cases.

Table I shows the types of encephalitis as ascertained from the medical histories. From this it will be seen that 27 were of the virus type, 16 of the toxic type, 5 of the traumatic type, and 2 unknown.

| TABLE I                                     |         |
|---------------------------------------------|---------|
| Types of Encephalitis                       |         |
| I. Virus Type                               |         |
| 1. Polioencephalitis                        | 4       |
| 2. Lethargic Encephalitis                   | 7       |
| 3. Influenza Encephalitis                   | 6       |
| 4. Measles Encephalitis                     | 3       |
| 5. Chickenpox Encephalitis                  | 1       |
| 6. Virusecephalitis of unknown origin       | 6       |
| Total                                       | 27      |
| II. Toxic Type                              |         |
| 1. Diphtheric Encephalitis                  | 2       |
| 2. Scarlet Fever Encephalitis               | 2       |
| 3. Pneumonia Encephalitis                   | 1       |
| 4. Whooping Cough Encephalitis              | 3       |
| 5. Meningoencephalitis                      | 1       |
| 6. Other toxic conditions of unknown origin | 7       |
| Total                                       | 16      |
| III. Traumatic Type                         | Total 5 |
| IV. Type Unknown                            | Total 2 |
|                                             | 50      |

In 40 cases the interval in years between the onset of the illness and the time of the onset of the problem was as follows:

|                                            |     |
|--------------------------------------------|-----|
| No interval or immediate onset in 27 cases |     |
| 1 year interval                            | 7 " |
| 4 year interval                            | 2 " |
| 7 year interval                            | 1 " |
| 10 year interval                           | 3 " |

In 10 cases, the exact time of onset of the problem could not be determined.

It is important to note that not one of the 50 cases was referred during the acute phase of the illness. All were referred much later when persistent behavioral or personality difficulties caused them to present problems to their homes or communities. In only 5 cases had the patterns of behavior shown by the children been recognized as causally associated with a previous attack of encephalitis.

The majority of children were referred for more than one type of behavior disorder. These ranged from such simple behavioral complaints as incorrigibility, truancy and temper tantrums, to the more severe types of anti-social conduct in the form of stealing, destructiveness, and other criminal acts, and finally to the serious abnormal types of behavior such as extreme restlessness, wanderlust, hallucinations, delusions, and other psychotic manifestations.

PSYCHOMETRIC TESTS

According to the results of psychometric tests made at the time of their admission to the Child Guidance Home, 2 children in this series rated superior, 16 were of average intelligence, 11 sub-average, 7 rated borderline, and only 14 were feeble-minded. In 20 cases, psychometric examinations were repeated several years after their dis-

missal from the Child Guidance Home. The I. Q.'s remained the same in 9 cases, improved in one case, and deteriorated in 10 cases.

Neurological findings were present in all but 9 cases. In 24 cases there were pyramidal signs, in 9 cases extrapyramidal signs, and in 16 cases ocular symptoms. Two children had persistent petit mal attacks and 5 suffered from grand mal seizures. Four children showed typical Parkinsonism.

At the Child Guidance Home every child is typed on a uniform personality chart. Thirty-two of the children in this series gave a personality rating which was characteristic. Temperamentally they were suspicious, impulsive, egocentric, and selfish. They had violent temper tantrums and were extremely obstinate. Emotionally they were highly unstable, lacked ability to concentrate (short attention span) and had very little self-control. Hence their actions were highly unpredictable and most often destructive and cruel. It was interesting to note that they had the same personality make-up as non-encephalitic epileptic children.

Their abnormal patterns of behavior can be readily divided into 3 categories: (1) Simple behavioral disturbances, (2) psychopathic types of behavior, and (3) psychotic types of behavior.

The children who came under the behavioral classification were restless and hyperactive and exhibited temper tantrums. They were noisy and domineering. Aggressiveness was an outstanding symptom. Stealing, lying, and running away were frequent occurrences. Enuresis was often present. These children were extremely difficult to control.

#### PSYCHOPATHIC BEHAVIOR

Of those who presented psychopathic types of behavior, some were phlegmatic and apathetic and apparently indifferent to what was going on around them. They gave the impression of being dull intellectually even though their intelligence quotients as shown on the psychometric tests were normal or above normal. They were asocial and made very little effort to enter into group activities. They concentrated poorly and were either unable or unwilling to carry out instructions. The majority of this group, however, were extremely restless, hyperactive, and lacked ability to concentrate. In many instances, they were vicious, cruel, and apparently deliberately abusive to other children. They were extremely anti-social and the unpredictability of their behavior was outstanding. Night terrors, sleep walking, respiratory difficulties, food fads, habit tics were frequent complicating symptoms.

Those children who were classified as psychotic showed severe disorganization of cerebral function. They were careless of their personal ap-

pearance and were slovenly in all their habits. Moodiness, crying spells, and irrelevant chatter were often noted. Outbursts of screaming and causeless laughter were also often present. Occasionally hallucinatory phenomena were in evidence. These, however, occurred but rarely. These children had no insight whatsoever into their condition.

As stated above, these children have been followed for periods ranging from 3 to 25 years, the majority having been followed for more than 15 years. Their present age range is from 10 to 42 years.

In the great majority of the cases, various types of social and medical therapy have been tried in order to bring about a social adjustment or at least an amelioration in the symptoms. The results as shown in Table II have been highly dis-

TABLE II

| Personality Rating and Present Social Status |  |   |    |
|----------------------------------------------|--|---|----|
| Typical—Adjusted                             |  | M | 3  |
|                                              |  | F | 1  |
| Unadjusted                                   |  | M | 24 |
|                                              |  | F | 4  |
| Atypical—Adjusted                            |  | M | 3  |
|                                              |  | F | 2  |
| Unadjusted                                   |  | M | 8  |
|                                              |  | F | 5  |
| Present Status                               |  |   |    |
| Typical—Adjusted                             |  |   | 4  |
|                                              |  |   | 28 |
| Total                                        |  |   | 32 |
| Atypical—Adjusted                            |  |   | 5  |
|                                              |  |   | 13 |
| Total                                        |  |   | 18 |

appointing. Only 9 cases of the 50 constituting the series are at present adjusted. An analysis of this small group does not give any clues that would indicate why these adjusted and why the majority of the group did not.

#### SUMMARY

Data on 50 cases of post-encephalitic behavior disorders and personality changes in children studied at the Child Guidance Home and followed for periods ranging from 3 to 25 years are presented.

(1) These data show that there were 39 males and 11 females, a ratio of  $3\frac{1}{2}$  to 1 which is much higher than the normal ratio of boys to girls studied at the Child Guidance Home (2 : 1). This would tend to show that males are more susceptible to this type of behavior and personality disorders than females.

(2) The age range of the onset of the disease was predominantly early in infancy, the bulk of the cases occurring before the age of 5 years.

(3) The age of onset of the behavior problems and personality changes was predominantly below the age of 10 years.

(4) In the majority of the cases, the onset of



the behavior and personality difficulties followed immediately the onset of the disease.

(5) The virus type of encephalitis predominated in this series.

(6) Neurological findings (pyramidal, extrapyramidal, ocular) were present in all but 9 cases. Five suffered from grand mal seizures, 2 from petit mal attacks, and 4 presented Parkinsonism.

(7) The I.Q. range was from 51 to 118. Only 14 were feeble-minded. Of 20 children who were retested, 9 showed no change in the I.Q., 1 improved, and 10 deteriorated.

(8) The behavior of these children while under observation at the Child Guidance Home could be divided into 3 categories: (1) Simple behavioral difficulties, (2) psychopathic, and (3) psychotic.

(9) Thirty-two had a characteristic personality make-up.

(10) Only 9 (6 boys and 3 girls) of the entire series of 50 cases are at present adjusted.

#### CONCLUSION

Encephalitis following acute virus or bacterial infections or cerebral trauma early in childhood may lead, in addition to structural cerebral changes, to behavioral and personality disturbances of such gravity as to prevent normal adjustment to life; this despite the fact that the intellect may be unimpaired.

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On the basis of data available from different parts of the country it is clear that there was a definite increase in the death rate from tuberculosis in many of the industrial cities in the north-central and northeastern part of the country last year, with a normal decline in other parts of the country. In Massachusetts the increase has been largely among the older age groups with an excess among males.—Alton S. Pope, M.D., *Massachusetts Bull.*, Dec., 1944.

### Progress Made In Cancer Control, Insurance Company Reports

The mortality from cancer, particularly among women, is beginning to come under control, experience among the many millions of industrial policyholders of the Metropolitan Life Insurance Company and other sources indicate. In the past decade, for example, the age-adjusted death rate from cancer among insured white females dropped 11 per cent at ages 1 to 74 years; virtually every important age group shared in the improvement. The current mortality from the disease among women in the broad age range 35 to 64 is the lowest in a third of a century, having dropped by one-fifth during that period.

Among white male policyholders, too, a favorable indication is noted. The distinctly upward trend which had been manifested for many years has been stemmed. In fact, during the past decade, at no age beyond 25 years has the cancer death rate among these men shown any increase, and at some age periods the mortality has tended downward recently.

That the organized movement to control cancer is bearing fruit is evident from the fact that people, and more especially women, are seeking diagnosis and treatment earlier in the course of the disease, when the chances of cure are best. For example, among the patients at the cancer clinics in Massachusetts, the average delay between first symptoms and visit to physician was reduced from somewhat more than six months in the period 1927 to 1935, to 3.3 months in 1943.

To give further impetus to this movement, the Metropolitan Life Insurance Company is conducting a special campaign during October. At that time, the Company's more than 20,000 field representatives, in cooperation in many communities with official and voluntary agencies, will distribute to practicing physicians a special packet of new information on cancer.

Included will be the American Cancer Society's booklet, "The General Practitioner and the Cancer Patient"; a reprint of recent studies of cancer mortality prepared by the statisticians of the Metropolitan; a reproduction of the Company's educational advertisement on cancer, "Cancer Has Its Hopeful Side!"; appearing during October in national magazines with a combined circulation of about 30,000,000 readers; and a copy of the Company's new leaflet for laymen, "There is Something You Can Do About Cancer". As part of this "message of hope about cancer", Metropolitan Field Representatives will endeavor to place the latter publication in more than one million homes. In addition, these representatives will place in prominent locations in their communities 6,000 window cards urging early diagnosis of cancer.



# Tuberculous Suprarenalitis

VIRGINIA CONGLETON, M.D., and ROBERT J. RITTERHOFF, M.D.\*

Case AE. 328. A 42-year old, white, single female was admitted to the Dunham Hospital on August 5, 1944.

**History:** In June of 1943, the patient developed malaise, shortness of breath, and extreme fatigue. These symptoms subsided in a week but returned 10 months later and were accompanied by loss of appetite and by pain over the epigastrium and both sides of the chest. After a short period in bed she improved sufficiently to return to her work, which consisted of arranging bakery goods on shelves. After a few weeks there was a recurrence of the former symptoms and in addition to these, slight fever. X-rays showed a minimal fibroid lesion in the apex of each lung. On admission her chief complaints were chest pain, vague discomfort in the epigastrium, and constipation.

The past history included the usual childhood diseases, scarlet fever, and influenza. She had pleurisy with effusion in 1935. Appendectomy was done in 1937. Transient dysuria was present in 1943 and 1944.

**Physical Examination:** T. 98.2; P. 72; R. 22; blood pressure 104/70. The patient was well nourished and did not appear sick. There were small, deeply pigmented, brown moles scattered over the body. The skin over the dorsum of the hands had a tannish hue; the skin was not pigmented elsewhere. Medium moist rales were present over the left upper lobe. Pelvic examination showed retrocession of the uterus.

**Laboratory Data:** Hemoglobin 12.6 gm.; erythrocytes, 4,080,000; leucocytes, 6,600 with 68 per cent polymorphonuclear cells; urine showed a trace of albumin and a few white blood cells; sputum was negative for tubercle bacilli; guinea pig inoculated with concentrated gastric washing showed no tuberculosis.

**Course:** After two months of bed rest and symptomatic treatment, the patient became ambulatory. Her pulmonary lesion was considered inactive. Numerous complaints of headache, malaise, insomnia, nervousness, and constipation were much less frequent and she began to gain weight. Five months after admission she complained of bilateral chest pain and X-rays showed a marked change with diffuse miliary lesions throughout both lung fields. She was returned to complete bed rest, was afebrile, and seemed to feel well for about six weeks. Then she began to have frequent nausea and occasional vomiting. X-rays showed increase in the densities throughout both lung fields.

At this time the blood pressure was 90/70. The lungs showed numerous moist rales over both upper lobes and over the right lower lobe. Examination of the heart and abdomen showed no abnormality. Kepler-Willson test<sup>1</sup> was done on April 30, 1945, and the ratio was 20, which is indicative of impaired adrenal cortical function. On the same day the serum sodium was 296 mg. per 100 cc. or 129 milliequivalents; the fasting

blood sugar, 164 mg. per 100 cc.; the blood urea nitrogen, 9.7 mg. per 100 cc. The patient was placed on a low potassium diet and given 8 grams of sodium chloride daily; it was planned to try desoxycorticosterone acetate if she failed to respond to this regimen. There was some decrease in the nausea but she showed signs of a rapidly spreading pulmonary lesion, with increase in cough, rapid respiratory rate, increasing rales, and rise of temperature to 103°.

On May 15, 1945, she developed dysuria and the catheterized urine showed a 1+ albumin and 20 to 25 leucocytes per high power field. Culture of urine yielded staphylococcus albus. The next day her condition suddenly became critical. When seen by the physician she was sitting up in bed and talking in a confused manner. Her hands were cyanotic and cold and her pulse was barely perceptible. The blood pressure could not be obtained. Five minutes later she was pronounced dead.

**Clinical Diagnoses:** Miliary tuberculosis of lungs, tuberculosis of suprarenal glands, acute cystitis, acute myocardial failure.

**Necropsy (T-45-14)** was performed twenty hours post mortem.

**Gross Examination:** The body, 158 cm. in length, was that of a well-developed, fairly well-nourished white female approximately 45 years of age. Numerous small, slightly elevated, tannish and brownish areas of pigmentation were present in the skin of the face, chest, abdomen, and dorsum of the wrists and hands. The skin of the wrists and hands appeared tanned. Pigmentation of the buccal mucosa was not found. The axillary hair was scanty. The panniculus was moderately thick and the muscles of the trunk were well developed. Slight pitting edema was present in the soft tissues of the feet and ankles. Dense grayish-white adhesions obliterated the pleural spaces and were present over the diaphragmatic aspect of the liver and spleen.

The lungs, of usual size and shape, were covered by loosely adherent, slightly thickened parietal pleura. The visceral pleura over the apices was puckered and opaque. Dissection revealed numerous, generally clustered, miliary tubercles diffusely studding generally dark red subcrepitant tissue. The apical and basal portions of the lungs were less involved by this process than the mid-lung fields. Linear areas of subpleural fibrosis, two to three mm. in thickness, were observed in the apices of the upper lobes. From these subpleural fibrotic deposits, slightly thickened gray septa and triangular grayish-black firm areas, five by eight mm. in dimensions, extended into the lung substance. Focally, throughout the upper lobes small irregular grayish-black areas studded by whitish tubercles were observed, and a lobular area of yellowish-white consolidated tissue, flecked by punctate tubercles, was present along the anterior basal portion of the left lower lobe. The bronchi were lined by glistening mucosa and that to the lingula was moderately dilated. Small, firm tracheobronchial lymph nodes on section presented dense anthracotic substance. A calcified nodule, two mm. in diameter, was present in one of the left lower bronchial nodes.

The suprarenal glands were approximately

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This is the twenty-fifth on a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., Professor of Pathology, University of Cincinnati College of Medicine.



three times their usual size; however, they were of normal shape. The adventitia and the capsules were moderately thickened and densely adherent to the surrounding structures. Multiple sections disclosed complete replacement of the cortical and medullary tissue by large confluent yellowish-white caseous masses, one to two cm. in diameter.

A moderate number of mucosal ulcers, one-half to one cm. in diameter, were present in the ileum and cecum. These ulcers presented nodular reddish over-hanging walls and granular purplish-red bases. Focally, the uterine fundal mucosa was thickened, granular and yellowish-white. Scattered throughout the substance of the liver, spleen, and kidneys there was an occasional minute tubercle.

The heart was of normal weight on the basis of body length, and valve measurements revealed moderate dilatation of all chambers, particularly those of the right heart. There was passive hyperemia of the viscera. Small portions of the inferior poles of the thyroid presented somewhat nodular thyroid substance traversed by thick and thin depressed communicating bands.

**Microscopic Examination:** Large nodular caseous masses, incompletely separated by thin deposits of collagen and generally surrounded by fibroblasts, epithelioid cells and monocytes, replaced the substance of the suprarenal glands. About the caseous masses, within the thickened capsule, and in the adventitial tissues there were tubercles composed of concentrically arranged epithelioid cells and either centrally or peripherally placed Langhans' giant cells. Many of the tubercles were free from caseation. No thrombi or inflammatory changes were observed in the adventitial vessels. Small islands of cortical tissue, either surrounded by tubercles or caseous masses or embedded in dense fibrous tissue were rarely encountered. The cells of these cortical masses, imperfectly arranged in cords, were larger than normal, somewhat irregular and granular, and moderately vacuolated. The nuclei of many were undergoing karyolysis and pyknosis. There was no recognizable medullary tissue.

Innumerable, generally clustered epithelioid tubercles were scattered throughout the lung framework. These were of varying ages as some consisted of concentrically arranged epithelioid cells with giant cells and inconspicuous caseation and others were partially replaced by coarse bands of collagen. There was a moderate number of framework and acinar caseous foci peripherally surrounded by monocytes and abortive tubercles. Generally, the bronchi were moderately dilated and many presented submucosal discrete proliferative tubercles and others, small caseous masses which projected into the lumen. Small pneumonic foci of monocytes and epithelioid cells were in direct relation to the involved focally caseous bronchi. Sections of the apices of the lungs disclosed subpleural, septal, and focal framework deposits of cellular collagen and elastic tissue sparsely infiltrated by lymphocytes. These fibrotic areas were not associated with any evidence of past or recent tuberculous lesions. An extra-pulmonic bronchial lymph node presented moderate congestion and hyperplasia of the reticulo-endothelium.

A moderate number of proliferative tubercles were present in the spleen, liver, and kidneys. Similar lesions were rarely encountered in the myocardium, thyroid, and cervix uteri. Ulcer-

ative mucosal lesions, characterized by monocytes, epithelioid cells, tubercles and caseous necrosis were present in the ileum, colon, and uterine fundus.

Multiple sections of thyroid revealed marked coarse interstitial fibrosis with slight lymphocytic infiltration, and nodular masses of small acini of the foetal type. The lining epithelial cells were pale staining and of the high cuboidal type. The majority of the acini did not contain colloid, and others were partially filled by vacuolated pale eosinophilic material. No lymph follicles were observed, nor was there any infolding or papillary formations of the acinar epithelium.

In sections of myocardium, other than that of the posterior papillary muscle in which there was one tubercle, there was a diffuse slight interstitial infiltration of monocytes and lymphocytes. A recent thrombus was adherent to the right atrial endocardium. There was marked passive hyperemia of all the viscera, most marked in the liver, where, in addition, there was marked central zonal hepatitis and necrosis.

**The pathological diagnoses were:** Massive bilateral caseous tuberculous suprarenalitis; extensive hematogenous pulmonary tuberculosis with foci of caseous tuberculous bronchopneumonia; ulcerative tuberculous enterocolitis and endometritis; miliary tuberculosis of the liver, spleen, kidneys, heart, thyroid, and cervix uteri; subacute diffuse interstitial myocarditis; right ventricular cardiac dilatation with associated passive hyperemia of the viscera; central zonal hepatitis; thyroid foetal adenomata; active chronic cystitis; fibrocalcereous tuberculous bronchial lymphadenitis; bilateral pleural fibrosis and minimal focal pulmonary fibrosis.

#### DISCUSSION

The extreme fatigue and malaise, which the patient described on admission, were more pronounced than one would have expected from the minimal extent of her tuberculosis even if the lesion had been considered an active one. The diagnosis of tuberculosis was presumptive since the gastric washing was negative on guinea pig inoculation. Decrease of complaints and symptoms when the patient became ambulant suggested that these might have been partly psychogenic. The return of symptoms was accompanied by X-ray evidence of marked increase in disease. The nausea and ease of fatigue were suggestive of Addison's disease, but these symptoms could easily be explained as part of the toxemic picture of miliary tuberculosis. The frequent complaint of weakness, which at least early in her course had no satisfactory explanation at this time, combined with a history of vague abdominal complaints, was impressive in retrospect.

Tuberculosis elsewhere in the body confused the picture and might have caused a failure to make the diagnosis of tuberculosis of the adrenal glands. The blood pressure was low but no lower than sometimes found in tuberculous patients who show no involvement of the suprarenal glands at autopsy. There were no other physical findings to substantiate the diagnosis. The Kep-



ler ratio of 20 and the low serum sodium were the best evidences in favor of Addison's disease. The addition of an acute cystitis to the hematogenous tuberculosis may have been a factor in the precipitation of acute adrenal insufficiency by increasing the bodily requirements to a point where they could not be met by the limited

Yet in view of the general incidence of Addison's disease, approximately one for every 6,000 cases admitted to the Mayo Clinic and a national rate of approximately 400 deaths per year<sup>3</sup>, it would appear that the incidence of Addison's disease is the same as or slightly greater in tuberculosis hospitals than that in general hospitals. Closer clinical observation with the help of thorough chemical and functional tests, particularly in view of the past reports<sup>4</sup> of bilateral massive tuberculosis suprarenalitis without clinical evidence of Addison's disease, would enable the clinician to differentiate the symptomatology of progressive tuberculosis and Addison's disease and thereby disclose a significantly greater incidence in the tuberculosis hospitals than heretofore supposed.

The primary source of infection is usually located in the lungs in from 30 to 50 per cent of the cases. Guttman<sup>4</sup> in a series of 243 tuberculous suprarenals with Addison's disease found active pulmonary tuberculosis in 88, inactive pulmonary scars in 36, either uni- or bilateral pleural adhesions in 45, disseminated miliary tuberculosis in 16, genito-urinary tuberculosis in 38, tuberculous lymph nodes in 54, tuberculosis in other sites, 51. Snell<sup>5</sup> in 1935, reported that of 21 patients with Addison's disease under observation at the Mayo Clinic at that time, 25 per cent had active tuberculosis, particularly of the surgical amenable types. Of the 17 cases of Addison's disease due to tuberculosis reported in negroes<sup>6</sup>, all had active tuberculosis elsewhere, and 65 per cent had active pulmonary tuberculosis. As in Addison's original report, it has, however, been frequently noted that<sup>3,4,7,8</sup> tuberculous suprarenalitis often occurs in association with apical pulmonary scars and apparently healed primary pulmonary tuberculous complexes.

The oldest active lesion in the present case appears to be in the suprarenals. In the absence of lesions elsewhere it can be assumed that the primary focus was in all probability the apparently healed primary pulmonary complex. The scattered areas of focal interstitial fibrosis in the apices of the lungs may represent foci of healed interstitial miliary tuberculosis which was part of the generalization which occurred at the time the suprarenals were involved. The suprarenals then in turn served as the source for the repeated hematogenous disseminations. With the development of bronchopneumonic foci, intracanalicular spread throughout the lungs and

terminally into the gastro-enteric tract subsequently occurred.

The absence of significant pigmentary changes, sustained blood pressure until two months before death, and relatively normal blood chemical findings would indicate that there was some functioning cortical tissue until a short time before death. Numerous clinical and experimental reports<sup>9</sup> have repeatedly demonstrated that hypotension, hypoglycemia, hypochloremia, and elevation of the urea nitrogen are inconsistent terminal findings. Morphologically, there was no apparent cause for the necrosis of most of the remaining cortical tissue. There was, however, a toxic factor as evidenced by necrosis and acute inflammation of the central portion of the liver lobules.

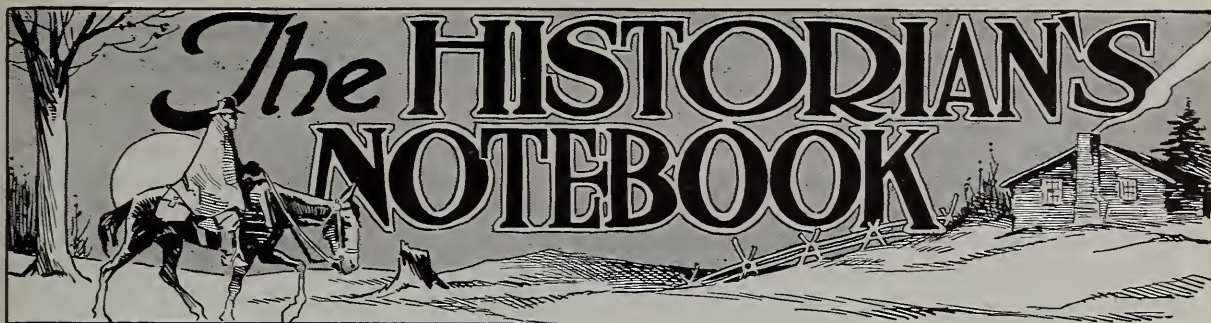
The significance of fibrosis and hyperplasia of the thyroid, which frequently accompanies Addison's disease is not understood.<sup>3, 11</sup> It is known, however, that administration of thyroid extract to adrenalectomized animals causes rapid death. And it is felt by some, clinically, that suprarenal cortical insufficiency<sup>10</sup> will cause hyperthyroidism. In the present case there were no clinical evidences of hyperthyroidism; however, pathologically, there were hyperplasia of the thyroid and abnormalities of the acinar colloid.

Profound hypoglycemia may have been responsible for the terminal collapse. However, in view of slight pitting edema, pulmonary basal rales, falling blood pressure in conjunction with the pathological findings of cardiac dilatation, subacute interstitial myocarditis, and marked passive hyperemia of the viscera it is more probable that the death was caused by cardiac failure. Experimentally, it has been shown that there is focal myocardial necrosis with inadequate desoxycorticosterone acetate, and Laipply<sup>8</sup> recently reported a case of Addison's disease in which there were subacute interstitial myocarditis, dilatation of the heart and evidences of cardiac failure.

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*Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio*

## An Eastern Doctor Visits Cincinnati

PHILIP D. JORDAN, PH. D.

### INTRODUCTION

“**W**HAT splendid place, friend, is this, which we are coming to?” asked Dr. Frederick Hall, standing on the deck of the high-pressure Ohio steamboat *Hunter*. “I have seen nothing in the West equal to it.”

“No, sir,” he answered, “nor will you, till you come back. It is the city of Cincinnati.”<sup>1</sup>

The Queen City stood proud and aloof on her hills the morning of June 11, 1837, and Hall noted that the temperature was mild, the air pure and balmy, and the sky cloudless.<sup>2</sup> He had left Reistertown, Maryland, on May 16 to “study the geological features of the country, and investigate its mineral resources.”<sup>3</sup> A physician and scientist of prominence, Dr. Hall had commanded the attention of the public as professor of Mathematics and Natural Philosophy in Middlebury College, Vermont; as president of Mount Hope College, Maryland; and as a member of the Connecticut Academy of Science. His other honors included membership in the American Geological Society; the Academy of Arts and Sciences of the Old Bay State; the New York Lyceum; and the Columbian Institute in Washington, D.C. He was to become corresponding secretary of the American Historical Society.

A man of wide interests and great personal energy, Hall recorded the results of two trips in a series of letters to his wife. In 1837, he moved by public conveyance from Maryland down the Ohio to Cincinnati and from there into Kentucky and Tennessee, where he visited Nashville and commented upon the health of that city. On July 24, 1838, he began the second of his tours from New York. This time he investigated the valley of the Connecticut River. His “Letters from the East, or from the valley of the Connecticut river,” first were published in

### *The Author*

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the *National Intelligencer* of Washington, D.C. His “Letters from the West” did not appear in the public press, but were first printed in a slight, reddish-brown bound volume entitled *Letters From the East and From the West* that was printed by F. Taylor and Wm. M. Morrison in Washington City and copyrighted on May 6, 1840.

Hall himself recounts how the account of his western and Ohio trip came to be included in the volume. “The history of the ‘Letters from the West’ is brief,” he wrote in his preface. “They were written more than two years ago, and transmitted, by mail, to the writer’s wife to cheer her loneliness. He cannot say, that they were composed for her amusement only. It was his design to spend a part of the following winter in re-writing, and preparing them for the type. Sickness confined him, the whole of that dreary winter, to his couch. His health, kind Heaven, in the spring, restored, and he set himself to the work of transcription. When the business was completed, the manuscript was offered, for sale, to three or four publishers, but they would not buy it. ‘We are willing,’ said they, ‘to print it, at your risk. But the world is full of books; none sell, except novels; the taste of the age is so dainty, it will accept of nothing, which is not strongly peppered; times are hard; money is scarce, and we cannot run the risk of buying a book of travels.’”<sup>4</sup>

Finally the author published, “like a tender

hearted father," the manuscript from his own funds. Now a rare item, the book is one of the more revealing of the many travel accounts written in the nineteenth century. Hall was a competent observer, a skilled scientist of his day, and a man not without the saving sense of humor. He was born at Grafton, Vermont, in November, 1780, and was graduated from Dartmouth College in 1803. He remained as a tutor there until 1805 when he went to Middlebury to teach until 1824. He then moved to Castleton, Vermont, where he received the degree of Doctor of Medicine in 1827. He died at Peru, Illinois, in July, 1843. At the time of his death, he was professor of chemistry at Columbian College, D.C.<sup>5</sup>

The following extract from *Letters From the East and From the West* gives one of the earlier descriptions of Cincinnati by a man of medicine from the East. As such it is an addition to the history of the region and gives insight into the Ohio country by one of the more prominent physicians, scientists, and educators of the day. The passages are reprinted without editorial change or comment.

#### THE EXTRACT

Cincinnati, June 12, 1837

Pearl Street House, Sunday, 10 P.M.

As soon as we could get our horse and carriage disembarked, we mounted, and rode directly to this House, which, we were assured, is the best hotel in the city. If this be the best, Cincinnati, is, in my humble opinion, much in want of a better public house—one, which shall correspond with the beauty, the opulence and the prosperity of the town. The stranger, arriving here in a boat, and surveying the rich exterior of the place, expects very naturally, to find in it first-rate accommodations—a Boston Tremont, or a New York Astor House; but the Pearl Street House, whether you regard the edifice itself, or its furniture, or the attendance of the servants, or the condition of the eating establishment, cannot be reckoned anything more than an ordinary hotel. In Baltimore, or Philadelphia, it would be styled a very common public house, and, I presume, that ten, if not fifteen, might be found superior to it, in either of those cities. Such an establishment as the Hotel de York at Florence, or such as the Exchange Hotel in Baltimore, is required in Cincinnati. It would be an ornament and an honor to the city, which would derive no small pecuniary advantages from it.

Having been prevented from hearing preaching during the day, I was resolved to enjoy that privilege, if practicable, in the evening. On enquiry, I ascertained, that the Rev. Dr. Beecher, with whom I was formerly acquainted, and who is now connected with the Lane Theo-

logical Seminary, situated about two miles from the city, was to deliver a lecture this evening in his church, which is only a few rods from the hotel. "Mr. S—one of his elders," said the bar keeper, "has just gone past." Mr. S——? who is this Mr. S——? I asked. "He is a gentleman, who has long been a resident here, has accumulated, honorably, a large estate, and who is esteemed one of our first lawyers, and one of our best men." Is he a bachelor? "No, Sir; he did enjoy single blessedness for about forty-five years, but, a few months since, he wisely bartered it away for an amiable, opulent widow, with four children, two sons and two daughters." Is he from New England? "Yes; Connecticut is his native State." I knew him well, said I, a quarter of a century ago, and have not seen him since. I will go, instantly, in search of him. I found him in his palace-like dwelling—there are not many private houses in Boston more magnificent—engaged in the humble, and yet Christ-like employment of instructing his smaller children in the doctrines and duties of religion. The interview was, I believe, mutually gratifying. I took tea with him and his accomplished lady, who seems every way worthy of him. In the evening, we attended Dr. Beecher's church and heard from this Rev. gentleman a very excellent discourse, which appeared to be entirely extemporaneous. After the exercises were concluded, I had the pleasure of renewing my acquaintance with Dr. Beecher, and with his talented daughter, Miss Catherine B. the authoress. To-morrow, I have engaged to visit them at their own dwelling near the "School of the Prophets."

June 12, Evening.

Tell Mrs. Mac L. that I have delivered her pretty, three-cornered, blue letter to Mrs. Stetson, with whose lady-like simplicity of manners, I was perfectly charmed. Her husband, she said, would call at my lodgings, in the course of two or three hours, for the purpose of carrying me out in his carriage to see the curiosities of Cincinnati.

We have had our excursion to the "Walnut Hills," on which are situated the Theological Seminary and the dwellings of its officers. The road thither is serpentine and hilly, but substantially made. In this *faubourg* of the city, the land appears not to have been long freed from its wilderness state. The size of the trees, still standing, bears testimony to the goodness of the soil. And if additional proof be demanded, it is afforded by the luxuriance of the vegetation, both in the fields and gardens.

The houses of the professors and other officers stand on a street, or road, broad, straight, and formed on a nearly horizontal plain.

After passing two or three of these, your attention is drawn to the Seminary building, whose lo-



cation is thirty or forty rods distant from the street, on the right. It makes a very respectable appearance, being four stories high, and one hundred feet in length. The chapel, seventy-five feet by fifty-five, has been made to assume the form, and style, of a Grecian temple. The Library comprises about four thousand volumes. Dr. Beecher's residence is beyond the Seminary, on the same side of the road. Him I did not see. Unexpected business had called him into the city. Mrs. B. and her son gave me a hearty welcome, and much information relative to the Institution. A farm, of one hundred and ten acres, is owned by the establishment, and the students are required to work on the farm, or at some mechanical business, three hours each day. Their present number is forty. The following gentlemen constitute the existing Faculty:

Rev. Lyman Beecher, D.D. Professor of Theology.

Rev. Baxter Dickinson, Professor of Sacred Rhetoric.

Rev. Thomas J. Biggs, Professor of Ecclesiastical History.

Rev. Calvin E. Stowe, Professor of Biblical Literature.

Dr. Beecher, as I have already intimated, is pastor of a church in the city. The affairs of this valuable seminary—this monument of the christian munificence of the people of the East and of the West—are managed by a corporation consisting of twenty-five members.

Dined to-day at Dr. Drake's, in company with the Rev. Mr. McGuffy, president of Cincinnati college. Dr. D. is one of the earliest settlers in the city, and is, probably, better acquainted with its history, than any other individual. He is the author of an elaborate "Description of Cincinnati," and, also, of a number of excellent "Essays on the natural history of the country around it." He is distinguished as a physician, as a medical professor, and as a man of science.

This city is becoming famous as a nursery of the fine arts, or rather, of artists. A gentleman took me, this morning, to a small shop, where we saw three full-length statues, nearly completed, carved out of hard sandstone, representing three individuals, with whom my conductor was well acquainted. "They are" said he, "perfect likenesses." The workmanship appeared to me to be of a high order—not equal to that of the Apollo de Belvedere, or the Venus de Medicis, but not at all inferior to that, displayed by the untaught Scottish sculptor, Thom, in his universally admired statues of "Tam O'Shanter, Souter Jonny, and the Landlord and Landlady"—a work, which will render the name of their author, as immortal as history. This artist, like Thom, has had no instruction, I am told, in the use of the chisel. His own native, unborrowed

talent and taste led him to employ it. A few years, spent in the studios of Rome, or Florence, would, I think, make him one of the first sculptors of our age. His name is Clevenger. We did not see him, as I hoped to do. He was absent.

Mr. Powers, the gentleman, who attracted so much attention, last winter at Washington, by his skill in moulding likenesses, is from this town, though a native of Vermont. He is, you know, shortly to embark for Italy to perfect himself in his profession. I promised to write him a letter of introduction to our worthy friend, Mr. Cicognani, late American consul at Rome. This promise I have, this day, fulfilled, and left the letter, as he requested, with Mr. Dorfeuille, the proprietor of the "Western Museum." Mr. D. invited me to examine the vast assemblage of curiosities, which his own individual enterprise and perseverance had enabled him to form. Besides the thousand and one articles, which are common to all museums, I was pleased to find an extensive collection of Indian, and other curiosities, which have been obtained in the Western States, many of which are full of interest for the antiquary. I observed, too, a number of wax figures, of surpassing beauty, formed by the hand of the sculptor, Mr. Powers, who was employed, during two or three years, at this establishment.

#### FOOTNOTES

1. Frederick Hall, Letters From the East and From the West (Washington, D. C., 1840), 106. The volume from the medical history collection of Philip D. Jordan.
2. Ibid., 105.
3. Ibid., 39.
4. Ibid., iv.
5. Appletons' Cyclopaedia of American Biography (New York, 1894), III, 40.

*(To be concluded in the December issue.)*

#### Committee on Cyclotronics

A Committee on Applied Cyclotronics has been appointed by Sen. Roscoe R. Walcutt, Columbus, chairman of the Ohio Postwar Program Commission. The committee's purpose will be to keep Ohio abreast of developments in the field of atomic energy through reports submitted to the commission, which was created at the recent session of the Ohio General Assembly. Medicine and industry are represented on the committee, as well as Ohio scientists who helped develop the atomic bomb. Physician-members include: Dr. Charles A. Doan, Dean, Ohio State University College of Medicine; Dr. Jay McLean, Columbus radiologist; Dr. Max Zininger, associate professor of surgery, University of Cincinnati College of Medicine; Dr. Robert A. Kehoe, University of Cincinnati's Kettering Laboratory of Applied Physiology.

# Recent Legislation and Its Effect on Ohio's Mental Hygiene Program

By FRANK F. TALLMAN, M. D.  
Ohio Commissioner of Mental Diseases

**I**NCLUDED in a review of action taken by the 96th Ohio General Assembly on matters affecting health and welfare, published in the August issue of *The Ohio State Medical Journal*, reference was made to legislative action



DR. TALLMAN

concerning the Division of Mental Diseases. The following material is a follow-up on that report and briefly answers the question, "What can the Division of Mental Diseases of the Department of Public Welfare accomplish as a result of the activities of the Legislature?"

The question and its answer are of interest to the medical profession in

this state, because the first clinical contact with the mentally ill, mentally defective and epileptic patient is with the practicing physician in the local community. He has the difficult task of interpreting to the patients, relatives, or friends the need for hospitalization and he can not feel satisfied unless he knows that the state's responsibilities in the care and treatment of this group are of the type that will satisfy his own professional judgment. Too often he has the difficult duty of explaining why admission for treatment and care must be delayed.

The Legislature provided \$15,789,836 for construction of new facilities comprising buildings for patients, quarters for physicians and employees, and other physical facilities such as kitchens, dining rooms, etc.

Translated into function, this means 3,215 ward beds for the mentally ill, and seven receiving hospitals with a total capacity of 1,222. This total of 4,437 means two things: first, that we will be able to decrease, to some extent, our

serious overcrowding and, secondly, that we will have increased facilities for new patients, particularly those whose illness is of short duration.

In thinking about this very considerable improvement, it is well to keep in mind that our total overcrowding is now about 4,800 and that if we were to completely relieve this with the present appropriation, no improvement of new patient facilities would be possible.

Reference has been made to appropriations for receiving hospitals. The term receiving hospital acquired significance in 1941 when the Legislature enacted sections in the laws governing this division making it possible to establish facilities either on the grounds of existing state hospitals or as separate institutions whose function would be that of accepting cases on a voluntary basis as referrals from physicians and also through orders executed by probate courts.

In other words, the provisions for admission are considerably liberalized so that patients can be encouraged to seek treatment in the early stages of their illness,

and so that even if they are not competent to come to this judgment by themselves, they can be placed in hospitals for a period of study and treatment without actual commitment. The final commitment takes place if the superintendent of the receiving hospital feels that prolonged treatment is necessary, and if the patient is unwilling or too ill to make an acceptable voluntary application.

Our state hospitals now receive voluntary

patients and also operate admission services with the same type of program as referred to above, excepting that they receive cases through courts only when committed.

The new money appropriated will provide more ample facilities for a number of our state institutions and will also allow new facilities in some sections of the state where the population is dense and where special needs exist. Patients retained in receiving hospitals will be those whose

**EDITOR'S NOTE:** The accompanying article was written by Dr. Tallman, Commissioner of Mental Diseases, Ohio Department of Public Welfare, at the request of *The Journal*.

This concise and enlightening review gives the medical profession of Ohio an authentic report on what effect the legislation enacted by the General Assembly in 1945 will have on the efforts which Dr. Tallman and the department are making to improve the state's mental hygiene program.

We are indebted to Dr. Tallman for the time which he has taken in the preparation of this analysis.



condition gives promise of speedy recovery.

It is of interest that money was also appropriated to provide buildings accessory to the aforementioned patients' quarters. For example—there are on the list kitchens, bakeries, power plants, and, of greater importance, new quarters for physicians, nurses and employees. This provision for residences for personnel is the beginning of a program designed to make the hospitals of the division more attractive.

The appropriation obtained will provide approximately 900 beds for ambulatory mental defectives and of perhaps more urgency, 690 beds for the younger mental defectives of the group who need infirmary and hospital care. This allows for an expansion of 1,550 beds. A new school, industrial building, and assembly hall are provided at one institution, as well as considerable service facilities. We can report, too, that a number of physician units can be provided.

#### CAN EXPAND TIFFIN INSTITUTE

For those suffering from convulsive disorders, the new money will provide 360 beds and also completely pay for the Tiffin State Institute which has a capacity of 600.

The Tiffin State Institute was planned for the treatment and education of individuals suffering from convulsive disorders whose condition was such that a reasonably early return to the community could be anticipated. Unfortunately, the superintendent of that institution resigned to accept a position of larger responsibility, and we have as yet been unable to find an epileptiologist to succeed him.

During the interval it is planned to utilize the facilities at Tiffin as a temporary dormitory to relieve some of our pressing needs for beds. When our new facilities are completed, patients will be removed and the institution utilized for its original purpose. Two physicians' units are also provided for this group.

#### CARE FOR TUBERCULAR CASES

The Legislature provided funds for construction of a new hospital on the site of the present Ohio State Sanatorium at Mount Vernon to house 550 mentally ill patients suffering from tuberculosis. When the present facilities there are converted to the use of this division, the total capacity will be about 700. Legal provision was made transferring the existing institution to the Division of Mental Diseases for the sole use of mental patients. This plan is a very definite step forward, because at the present time each institution attempts to take care of this difficult problem without adequate facilities.

The Youngstown Receiving Hospital, the remodeling of which is nearly completed, will also be purchased out of the appropriation. This small institution of 85 beds will help to relieve

the situation to some extent in Northeast Ohio, and will provide an opportunity to try various types of programs.

#### FUNDS FOR REPAIRS

The institutions of the division have been badly in need of repair and rehabilitation for a number of years, and in recognition of this the Legislature appropriated \$3,360,664 for this purpose.

On the legislative front, changes and additions were made to the laws governing this division of the Department of Public Welfare. The name was changed from the Division of Mental Diseases to the Division of Mental Hygiene, and appropriately the word "hygiene" was substituted for the word "diseases" in all sections in the act applying to this division. This change is worthwhile, because the new term implies that the division is concerned with an over-all program which includes much more than the operation of the institutions.

The provision for voluntary admission was broadened to include individuals suffering from convulsive disorders. Applications made for all voluntary admissions must be accompanied by a letter of referral from a physician. In the old law there were certain administrative restrictions having to do with the time that a voluntary patient might remain in the hospital. These were eliminated, so that our procedure is now equivalent to that of any general hospital.

Legal powers were granted the division in the matter of establishing a system of out-patient mental hygiene clinics, and in the placing out of suitable individuals for family care.

#### DEFINITION MODERNIZED

The definition of mental deficiency was brought up to date and the references to specific intelligence quotients were eliminated. This is an important advance, because heretofore if a patient had an I.Q. of about 69 he could not be admitted to a school for the mentally defective. As it is now, the diagnosis is left to a matter of medical judgment. Another definition that was included was that of psychopathic offender, made necessary because of the confusion that existed in the old act with reference to terminology.

Legal machinery was set up providing for mandatory examination before sentence of all individuals convicted of certain sex crimes. There is a section also that makes it possible at the discretion of the court for a similar examination of anyone convicted of a felony, except murder in the first degree when mercy has not been recommended, when it is suggested to the court that such a person is a mentally deficient offender, or psychopathic offender.

In brief, these legal changes recognized that some crime is definitely a medical problem and that those criminals who are mentally defective

or psychopathic need to be provided quarters and treatment of a different type than can be arranged in a prison. There are a number of other changes which are administrative and which are not of particular interest to our profession.

### THREE IMPORTANT STEPS

The three items now to be discussed are significant, not only because of the programs that they represent, but because they illustrate the willingness on the part of the Legislature to expand the program of the division in certain directions. It is true that the amounts allotted to us are small, but it seems fair to say that the recognition of the need is, in the end, more important than the amounts appropriated.

We received (for the biennium) \$25,000 to initiate a new program looking toward the care of certain carefully selected mentally ill individuals in private homes. This program not only implies the custody of so-called comfortable patients but it makes possible placement of patients for therapeutic purposes, particularly in the matter of the transition from institutional living to community living.

The budget contains \$9,250 for the use of our Bureau of Mental Hygiene Information. The bulk of these funds will be expended for the making of visual aids for training attendants and for the instruction of teachers with respect to personality development.

A final item of interest is \$25,000 for research. The Legislature is to be complimented upon its understanding of the lack of sufficient research in the matter of mental illness. It is true that the amount received is not great, but it is a token appropriation which will allow us to begin a program in cooperation with the well established research organizations in the state.

### CLINICS BADLY NEEDED

A request was made for a sum of money to initiate a program of mental hygiene clinics, but unfortunately no money was obtained. This failure is serious. Anyone who has attempted to find mental health out-patient facilities for returning soldiers knows of the acute need. It is also serious, because, like other diseases, mental illness responds to treatment much more favorably in earlier stages. We had hoped that it would be possible to initiate an out-patient program which would include those physicians in the community who were interested in acquiring a greater knowledge of this specialty, particularly in reference to psychosomatic medicine.

The Legislature appropriated a relatively small increase in funds for the employment of personnel in the institutions of this division. Programs and buildings are of little value unless there is a staff sufficient in quantity and quality

to make the project constructively operative. The great need has always been a more adequate salary schedule together with enough money to employ sufficient people. This Legislature did not recognize this all important problem.

### SUMMARY

In conclusion, it may be said that the action of the last General Assembly will make it possible for the division to reduce to some degree the serious overcrowding now existing and to provide a more rapid intake of more new patients suffering from mental illness, mental deficiency, or convulsive disorders. The funds allowed will provide a special project at Mt. Vernon for tuberculous mentally ill patients, thus relieving the state hospitals of the need to care for this special group and aiding immeasurably in the control of tuberculosis.

Another highlight in the picture is the provision of funds for the Youngstown Receiving Hospital which will open in the near future.

In the matter of program, new funds will allow for the family care placement of suitable patients both for custody and convalescence, an enriched training course for attendants, and a definite program of interpreting mental illness to the general public. A very bright spot was the provision of a small sum for the inception of a research program.

In the main, the new legislation liberalized and brought closer to the medical point of view the mental hygiene laws. Specific powers and authority were given the courts and the department with respect to the mentally defective offender and the psychopathic offender.

This brief statement shows that the 96th General Assembly made a good beginning in improving the mental health program of the state. It should be stressed that what has been done is largely in the nature of catching up, particularly insofar as the building program is concerned. There is still a big job to be done in providing sufficient personnel to make our program fully active.

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### Mental Deficiency Assembly

The Sixty-Ninth annual meeting of the American Association on Mental Deficiency will be held at the Hotel Cleveland, Cleveland, Nov. 28-Dec. 1. The program, as arranged, will present sections on institutional administration, research, psychiatry and medicine in the field of mental defect, psychology and teacher training. Details concerning the meeting can be obtained by addressing the chairman of the Committee on Publicity, Dr. Gale H. Walker, Pole State School, Polk, Pa.



## Application for License To Begin Business Filed by Ohio Medical Indemnity, Inc., With Insurance Superintendent

OHIO MEDICAL INDEMNITY, INC., the company organized through the initiative of the Ohio State Medical Association and eight of Ohio's Blue Cross Hospital Service Associations to provide cash indemnities against medical, surgical and obstetrical expenses has filed an application with the State Superintendent of Insurance for a license to commence business and to issue contracts to subscribers.

As soon as the Division of Insurance completes its usual investigation preliminary to issuance of a license and the company receives its license, Ohio Medical Indemnity, Inc., will begin the transaction of business, in cooperation with the Hospital Care Corporation of Cincinnati, in approximately 14 Southwestern Ohio counties composing the territory covered by the Cincinnati Blue Cross program.

At a meeting of the Executive Committee of Ohio Medical Indemnity, Inc., on October 10 the contract of indemnities which will be offered to subscribers was officially approved for submission to the Superintendent of Insurance. Also, plans were completed for the appointment of a general agent for the Cincinnati area and an agreement between the company and the Hospital Care Corporation of Cincinnati for sharing of expenses incurred in connection with administrative procedures was drafted.

Mr. Charles H. Coghlan, executive vice-president of the company, is maintaining offices temporarily in the Headquarters Office of the Ohio State Medical Association, 79 East State Street, Columbus 15. As soon as suitable office space is available, home offices of the company will be opened elsewhere in Columbus. When Ohio Medical Indemnity, Inc., obtains its license to transact business, Mr. Coghlan will concentrate his attention on activities in Cincinnati and the rest of the area covered by Hospital Care Corporation of Cincinnati. However, as soon as feasible, the company will begin to do business in other parts of the state, exclusive of the Cleveland area, in cooperation with other Blue Cross Hospital Care Associations.

Members of the Board of Directors of Ohio Medical Indemnity, Inc., are of the opinion that the Cincinnati area offers an ideal situation for the initial activities of the company due to the fact that there are approximately 500,000 residents of that section of the state who are Blue Cross subscribers at present.

The Board feels that the company can gain a great deal of valuable experience on administrative procedures and problems by starting operations in that area, where a general pattern for joint operations with Blue Cross plans elsewhere can be formed.

Stock certificates are now being printed and in the near future they will be transmitted to the approximately 600 physicians who subscribed for one or more shares of preferred stock issued by Ohio Medical Indemnity, Inc.

Members of the Executive Committee, which has been handling the final details in completing the organization of the company and preparing documents necessary for obtaining a license from the Superintendent of Insurance, are: Dr. Carl S. Mundy, Toledo, chairman; Dr. Robert C. Rothenberg, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. William M. Skipp, Youngstown; Dr. R. K. Finley, Dayton; Dr. E. P. McNamee, Cleveland; The Most Reverend Karl J. Alter, D.D., Toledo; Mr. E. C. Pohlman, Columbus; and, ex officio, Dr. L. H. Schriver, Cincinnati, the President; Mr. C. H. Coghlan, Columbus, the Executive Vice-President, and Mr. Charles S. Nelson, Columbus, the Secretary-Treasurer.

Assistance has been given to the Executive Committee on these matters by Mr. James E. Stuart, Cincinnati, and Mr. Ralph W. Jordan, Columbus, vice presidents of Ohio Medical Indemnity, Inc., and executive directors, respectively, of Hospital Care Corporation of Cincinnati and Central Hospital Service of Columbus; and by Mr. Wayne E. Stichter, Toledo, general counsel of the indemnity company.

Complete details with respect to the provisions of the indemnity contract and administrative procedures will be published in *The Journal* and publicized to members of the medical profession in other ways as soon as the Superintendent of Insurance issues a license to the company.

## "Veterans' Inquiry Department" Opened by The Journal; Purpose, Scope and Rules Governing New Feature

A NEW department will be inaugurated in The Journal in the December issue to be known as the "Veterans' Inquiry Department", providing this announcement produces a response on the part of returning medical officers.

The purpose of the new department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, and similar questions having to do with further training or establishing a practice.

These regulations will govern the submission and insertion of inquiries:

1. The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered the service.

2. Inquiries should not exceed 35 words.

3. Copy must be submitted by the 20th day of the month preceding date of publication.

4. Unless otherwise specified, each inquiry will be carried in two consecutive issues of The Journal and no oftener.

5. The Journal reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant.

6. Inquiries should be accompanied by full name, forwarding address and identifying data.

### Procedure For Purchase of Surplus Medical Property Outlined

Surplus property of the Army Medical Department may be purchased by veterans through the Smaller War Plants Corporation, which has six offices in Ohio. The procedure to be followed by a veteran who desires to purchase such items as would assist him in re-establishing himself is outlined in Paragraph 8307.3 of Surplus Property Board Regulation, reading as follows:

"Any veteran desiring to exercise the preference hereby granted in the purchase of surplus property useful to establish or maintain his own small business or professional enterprise shall file an application for such property with the district office of the Smaller War Plants Corporation for the locality within which he maintains or intends to establish such enterprise."

District offices of the Smaller War Plants Corporation are located in the following Ohio cities: Canton, 717 First National Bank Bldg.; Cincinnati, 38-40 E. 4th St.; Cleveland, Union Commerce Bldg.; Columbus, 145 N. High St.; Dayton, 129 S. Ludlow St.; Lima, Colonial Finance Bldg.

Only 20 people in every 100,000 in the United States will die from tuberculosis in 1960 if the present rate of improvement continues, statisticians of the Metropolitan Life Insurance Company estimate. The comparable death rate from the disease has decreased from almost 200 at the turn of the century to 100 in 1921 and about 40 at present.

### Radiological Society Ready To Aid Returning Veteran Physicians

The Ohio State Radiological Society has announced that it will be glad to act as a clearing house between returning veterans who are radiologists and any established radiologist or hospitals concerning placement problems.

Those who may desire this assistance should communicate with Dr. Henry Snow, secretary of the Ohio State Radiological Society, 1064 Reibold Bldg., Dayton 2, Ohio.

### Col. Rusk Joins Baruch Group

Dr. Frank H. Krusen, Director of the Baruch Committee on Physical Medicine, has announced the appointment of Colonel Howard A. Rusk, Medical Corps, Army of the United States, as Consultant on Physical Rehabilitation for the Baruch Committee. Colonel Rusk, whose pioneering work as Chief of the Convalescent Division of the Air Surgeon has attracted national attention, and who has resigned from the Army, will make his headquarters at the New York office of the Committee.

The Committee plans to set up a blueprint for the guidance of communities in the establishment of community rehabilitation centers or services.

Colonel Rusk, before the war, practiced internal medicine in St. Louis and also was instructor in medicine at Washington University School of Medicine there.



## Special Services Established in Columbus Office of State Association To Assist Returning Veteran Physicians

**I**N cooperation with the Committee on Education of the Ohio State Medical Association and Procurement and Assignment Service for Physicians, the Columbus office of the Ohio State Medical Association has established a special service to supply Ohio physicians returning from military service with information which will assist them on matters of location, postgraduate training, etc.

Here are some of the services which the Columbus office is prepared to render returning veterans:

1. Supply them with a file providing information on the following:

- (a) Residency training offered by approved Ohio hospitals;
- (b) Residency training offered by approved hospitals in other states;
- (c) Refresher and review courses offered by Ohio's three medical schools;
- (d) Refresher and review courses offered by schools and institutions in other states.

2. Provide them with information regarding the educational provisions of the G.I. Bill, including data on the amounts allowed for tuition, subsistence benefits, etc.

3. Provide them with a list of Ohio areas where the services of a physician for civilian practice are needed immediately.

4. Provide them with statistical and factual data, having a bearing on the practice of medicine, on any Ohio community.

5. Obtain from authentic sources, if possible, data and information which may be sought by the veteran physician and which is not immediately available from the files of the Columbus office.

6. Publish in The Journal, without cost, inquiries submitted by veteran physicians, the new department to be known as the "Veterans' Inquiry Department". (See explanatory box on page 1032).

At the request of the Ohio State Medical Association, the Ohio Department of Education, which is recognized by the Veterans Administration as the official certifying agency for institutions where veterans may continue their education under the provisions of the G.I. Bill, has placed on its certified list all Ohio hospitals approved by the Council on Medical Education and Hospitals for intern and residency training.

Civilian physicians who may have opportunities to offer returning medical officers should transmit such information to the State Association's Columbus office so it can be made available to veteran doctors. In other words: Do you want an associate or locum tenens? Have you office space to share or rent? Have you a practice, office or equipment for sale? Do you know of openings which might interest the returning physician? Such data will be helpful in efforts to establish or re-establish the returning medical officers in civilian practice.

In addition, representatives of the State Association have been in constant touch with Ohio's congressmen on the question of immediate release of physicians from the services. Emphasis has been placed on the need for lowering of the point systems for discharge and the release of certain low-point physicians for civilian practice in areas where the need for physicians is critical.

The Association has received splendid cooperation on these matters from Ohio's congressmen, many of whom have made strong representations to the War and Navy departments and the Public Health Service, urging modification downward of the point systems and release of certain physicians for acute areas.

Those who desire up-to-date information on certain phases of these matters should review the following articles which have been published in The Journal; page 930, October, 1945, issue; page 833, (Council Minutes) September, 1945, issue; page 754, August, 1945, issue.

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### YOU CAN'T DO SOMETHING WITH NOTHING

In the October issue of *The American Journal of Public Health*, Dr. Thomas Parran, surgeon general of the United States Public Health Service, offers some thought-provoking observations regarding public health activities in the reconversion period. Among other pertinent statements, Dr. Parran said:

"A very large share of the public health accomplishment during the war has been made possible under wartime appropriations of the United States Congress . . . State and local health agencies must look forward to taking over a larger part of the cost of these basic public health services. The needs for them will be no less during the reconversion than in wartime; in fact, needs will be greater."

Dr. Parran analyzes certain weaknesses in state and local health programs, referring especially to the serious shortage of trained personnel and the foggy policies and thinking which still exist in too many health departments.

These are real challenges to Ohio. If the Ohio Department of Health had to operate on appropriations made from state funds, it would be a tragic case of malnutrition. Some of its important activities are financed at present almost entirely with Federal money. Its experience in trying to secure trained personnel has been very spotty.

A good many local health departments in Ohio are operating on starvation budgets. If most of them were not recipients of a little state aid and some Federal assistance, they would have to curtail their activities to the point of potential disaster for the area served.

It's about time for Ohio and its local subdivisions to wake up. Efficient public health activities can not be carried on generally throughout the state under present conditions. One thing we can be sure of: The job is going to be done—the people are going to demand that. The question is: How? If through larger Federal appropriations, then Ohio will be giving away more of its rights and privileges to Washington. If we don't want that—and we don't—then the only alternative is to see that our state and local health departments are given more financial support out of state and local treasuries.

Let those who yell bloody murder about Federal interference and domination ponder this matter. Let them get busy in their own communities.

This applies to county medical societies among

others. It's time for the medical profession through their organizations to take the lead and put on the heat on a state and local basis.

If the profession will act, it should have no great difficulty in showing the public weaknesses in present public health programs and in getting the taxpayers to demand that those who have charge of the expenditure of public funds provide more adequately for our health departments.

The only alternative is more and more Federal supervision and bigger and bigger Federal appropriations. Let those who want none of that, act.

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### MILLER WELL QUALIFIED FOR SECURITY POST

Appointment by President Truman of Watson B. Miller as Federal Security Administrator indicates that this important agency will be in capable hands. Miller has served four years as assistant administrator under Paul V. McNutt. He is familiar with the machinery of the department and judging from his record has his feet on the ground.

From the medical and health angle his job is big and important as such services as the Public Health Service, Food and Drug Administration, Social Security Board and Procurement and Assignment Service come under his direction.

Mr. Miller is well known to many Ohio physicians, especially World War I veterans and members of the American Legion. A native of Indiana, he was for 18 years national rehabilitation director for the American Legion. Through training, experience and temperament, Miller should prove to be an efficient administrator and one who will not be shoved around by star gazers.

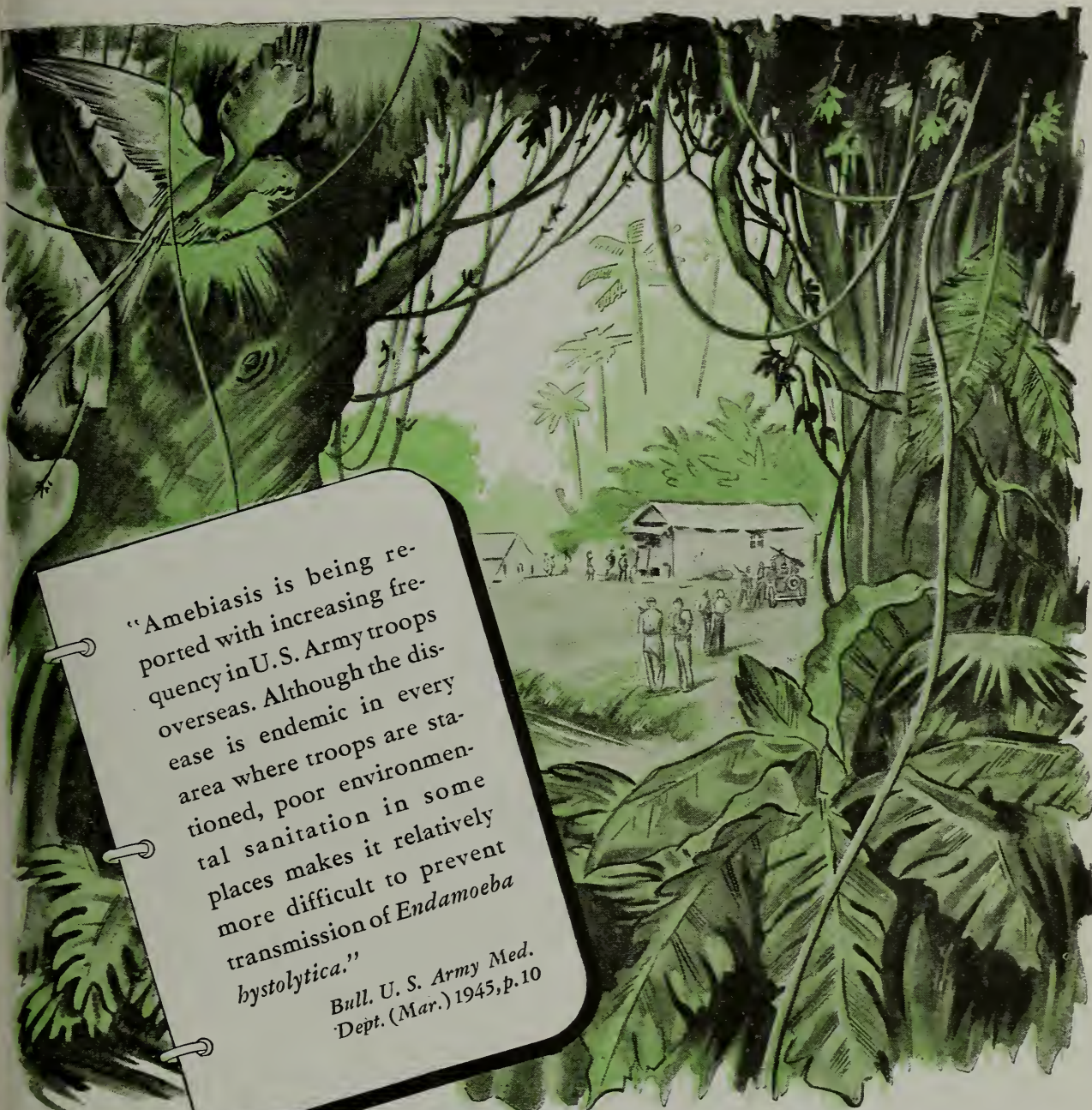
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### COMMON SENSE IN MEDICAL CARE OF VETERANS

Judging from the remarks which he made at a Public Relations Conference in Chicago, October 19-20, sponsored by the Council on Medical Service and Public Relations of the American Medical Association, Maj. Gen. Paul R. Hawley, medical director of the Veterans Administration, wants to instill a lot of common sense in the medical care program for disabled veterans.

General Hawley, who incidentally will be one of the guest speakers at the Ohio State Medical Association Conference of County Society Presidents and Secretaries, November 11, at the Deshler-Wallick Hotel, Columbus, outlined in some





"Amebiasis is being reported with increasing frequency in U. S. Army troops overseas. Although the disease is endemic in every area where troops are stationed, poor environmental sanitation in some places makes it relatively more difficult to prevent transmission of *Endamoeba histolytica*."

Bull. U. S. Army Med.  
Dept. (Mar.) 1945, p. 10

Amebiasis can no longer be considered a "tropical disease"—it has recently been described as endemic in New York as well as in other sections of the country.

## D I O D O Q U I N

(5, 7-diiodo-8-hydroxyquinoline)

is safe for use whenever amebiasis is suspected, or administration, over protracted periods without ill effect. Diodoquin contains 63.9% iodine, is destructive to *E. histolytica* and *Trichomonas hominis*.  
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RESEARCH IN THE SERVICE OF MEDICINE



detail his views and plans. Space will not permit an analysis of his remarks. However, the theme of his talk was that the Veterans Administration must and intends to work closely with physicians in private practice and will welcome the inauguration of any local medical society program which is feasible and will meet the needs and conditions of the specific area.

Cited by General Hawley as an example of good planning on sound principles was the program which has been proposed by the Monmouth County (New Jersey) Medical Society and favorably received by the Veterans Administration.

The Monmouth County plan was outlined by the president of that society in a letter to the *New York Times* and republished in the September 15 issue of the *New York State Medical Journal*.

For the information of County Medical Society officers and committees in Ohio who are considering this big and important question, excerpts of that communication are presented:

"The Monmouth County plan is, briefly, as follows: All members of the Monmouth County Medical Society who are willing to serve will be designated as outpatient physicians on a fee basis for the Veterans Administration—this will be approximately 90 per cent of our membership. The society will supervise the work to make sure that the veterans are given proper care.

"In addition, at convenient places in the county, at such intervals as the volume of work requires, there will be screening clinics. These will be staffed by specialists in several fields—internal medicine, general surgery, orthopedic surgery, eye, ear, nose, and throat, psychiatry, etc.

"To these clinics the returning veteran may come, having authorized the Red Cross to obtain his Army medical record. On the basis of this record and their own findings the clinic staff will determine whether the veteran needs treatment and whether such treatment can be carried out at home or requires hospitalization.

"If he can be treated on an outpatient basis, he will be shown a list of physicians qualified to treat his particular condition, from which he makes his choice. If he has no choice, he will be assigned to a physician convenient to his home. The Veterans Administration will provide the necessary clerical work and will also provide a liaison officer to authorize the referral.

"Plans are also being made to permit hospitalization of the veterans in local general or specialized hospitals. It should be stated that this had already been proposed by the Veterans Administration before the medical society suggested it.

"The Monmouth County plan preserves the individual doctor-patient relationship and avoids the psychologically bad situation of being treated by a government doctor in whose selection the patient has no part. It also will obviate the hardship of traveling long distances to a veterans' clinical center.

"It is based on the principle that before he was a soldier a man was a citizen, and that as a veteran he has certainly lost none of the rights of a citizen. Our Monmouth County plan, it seems to us, preserves intact one of those

rights, and if it adds something to the medical service rendered to the nonveteran citizen, it is little enough for us to do for those who have fought our wars for us."

The program suggested by the Monmouth County Medical Society may not be feasible in all Ohio counties and there undoubtedly will be other suggestions just as good. Nevertheless, it does offer some valuable ideas which deserve careful consideration by all County Medical Societies who, sooner or later, are going to be confronted with a challenge from the Veterans Administration (if General Hawley has his way) to do the job—and in a way which will give the veteran the best possible medical care and preserve the principles of the medical profession.

### IF IT ISN'T SOCIALIZED MEDICINE WHAT IS IT, SENATOR?

To the contention of Senator Robert Wagner and his followers that the notorious Wagner-Murray-Dingell Bill would not create a system of socialized medicine, the *Christian Science Monitor* makes this apt reply:

"Obviously, when a compulsory system of government-medical-care insurance is set up to embrace the bulk of a people, that is socialized medicine. When the Government hires doctors like postmen and pays them salaries, that is state medicine. The Wagner-Murray-Dingell Bill provides for both."

This is a good point to make to those who may wish to argue that Senator Wagner's baby is not socialized or state medicine.

### SHALL THE DOCTOR TELL HIS STORY?

It's beneficial for the medical profession to know what others think of it. By learning how others regard them as a group, physicians can make adjustments to bring about a better understanding between the profession and the public.

In our opinion, the matter is summed up pretty well and some good advice handed out in an article published in the *Erie County (Pa.) Medical Bulletin* and written by Thomas Cook Brown, editorial writer of the *Buffalo-Courier-Express*.

In his article entitled, "Shall the Doctor Tell His Story?", Brown makes these pertinent observations which should be awakening to the medical profession:

"Way back in the days when the first newspapermen were drawing mastodons on the walls of caves and the first medical men were saying 'now cough' to the young warriors, our two professions ought to have tried to understand each other. Maybe they tried. If so, they didn't succeed.

"In times within the memory of most of us, the medical profession and the press still were far from mutual understanding. To illustrate: Not many years ago, physicians thought of a



**BY INJECTION**

... subcutaneously or intramuscularly, ADRENALIN provides rapid symptomatic relief in asthmatic paroxysms; is useful in the prevention and treatment of other allergic reactions; localizes and prolongs the action of local anesthetics. Intravenously, it is used in shock and anesthesia accidents.

**BY APPLICATION**

... for its vasoconstrictor action in hemorrhage, ADRENALIN permits better visualization of the field, and aids in the diagnosis and treatment of certain conditions encountered in ear, nose and throat practice.

**BY INSTILLATION**

... into the nasal passage, ADRENALIN produces prompt decongestion; in the eye ADRENALIN decreases vascular congestion, and aids in the location of foreign bodies.

**BY INHALATION**

... orally, ADRENALIN relieves severe attacks of bronchial asthma by relaxing the bronchial muscles.

Its remarkable ability to stimulate the heart and increase cardiac output, raise the blood pressure, constrict the peripheral arterioles, dilate blood vessels of voluntary muscles, and relax bronchial muscles . . . makes ADRENALIN one of the most versatile and useful therapeutic agents at the command of the physician. Little wonder, then, that

it's always kept close at hand in operating room, office, and medical bag.

To permit full use of its many therapeutic applications, there is a form of ADRENALIN (Epinephrine) to meet every medical need: Solutions of 1:100, 1:1000, 1:2500, 1:10,000; Suspension of 1:500 in oil; and Inhalant, Suppository, and Ointment.

**ADRENALIN**  
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newspaperman as a peculiarly noxious individual who barged into places where he wasn't wanted, took voluminous notes on things he wasn't supposed to hear—and then transcribed his notes all wrong. To make himself even more insufferable, he puffed cigarette smoke in your face, jested loudly over medical terms and called you 'Doc'.

"This, of course, was an absurd and outrageous caricature of the real newspaperman; but it passed for a picture in many physicians' minds—now, didn't it? You needn't indulge in polite protests. Many a newspaperman had the doctors wrong, too—not his own physician (a good fellow and an exception) but medical men *en masse*. He thought of medical society meetings as frigid and funeral gatherings from which reporters were excluded as enemy aliens. After locking the doors and windows and peering under the furniture for spies of the press, the doctors were supposed to sit around, stroking their beards and thinking great thoughts while the more ancient among them turned loose a flow of learning and Latinity. This, too, was an absurd and outrageous caricature. But how was the reporter to know? Those were the days when you didn't let him in.

"Times have changed. The average American physician now recognizes the average newspaperman as a reasonably intelligent practitioner of a profession—a profession not comparable to the physician's own in precision of standards or in rigidity of discipline; but, nevertheless, a profession. True, the newspaper profession can not protect itself from the intrusion of charlatans as the medical profession does. That is part of the price we pay for freedom of the press. But the journalistic quacks make up only a small proportion of the craft—a surprising fact, in view of the constitutional guarantees which permit them to practice without licenses.

"As the doctor has come to know the newspaperman better, he has told the latter at least part of his story; and that part of the doctor's story has been passed on to the world. I have said that the newspaperman, like almost everybody else, thinks rather well of his own medical adviser; but only recently has he come to see the medical profession clearly and to see it whole.

"What he has seen impresses the average newspaperman most favorably. There is neither time nor space to tell all the reasons why. Let us take just one example—the hardy perennial, 'socialized medicine'. The dispute over 'socialized medicine' never can be resolved in orderly manner until both sides arrive at a common definition of the term. Thus far, they have reached only half a definition. Both sides mean the same thing when they say 'medicine'. It is on the word 'socialized' that the debaters part company.

"When you think it through, you realize that the medical profession is the only one—except possibly the clergy—which is socialized in the best sense of the word. It is the only nonreligious profession which requires its members to serve without recompense (and often without thanks) their fellowmen in need. If this is not socialization—voluntary self-socialization, but still socialization—of a profession, what is?

"In most of the arguments over 'socialized medicine', however, what really is meant is a state of affairs whereby the patient would be socialized. That is the real danger which physicians and laymen must fight, if the medical profession is to preserve its existing standards of social responsibility—standards so far above those of the profession's political critics that

most of the criticism is impudence which can be excused only on the ground of ignorance.

"All this is plain from the small part of the doctor's story which already has been told to the press and retold to the world. Shall the rest of the story be told? That is up to the medical men. Their answer may be that the story has been told and is being told on a thousand fields of battle and at a million beds of pain; that it needs no further crying from the housetops.

"Perhaps that is the right answer; but I don't think it suffices. There is much of a great and gallant story still untold. When the doctors are ready to tell it, the press will be ready to make sure that it is heard."

### CURB ON THE MISUSE OF BARBITURATES NEEDED

American pharmacy is coming to grips with the problems arising from promiscuous distribution of barbiturates, according to a bulletin issued recently by the American Pharmaceutical Association, summarizing action taken at a conference held in Washington under the auspices of the Committee on Legislation of the A.P.A.

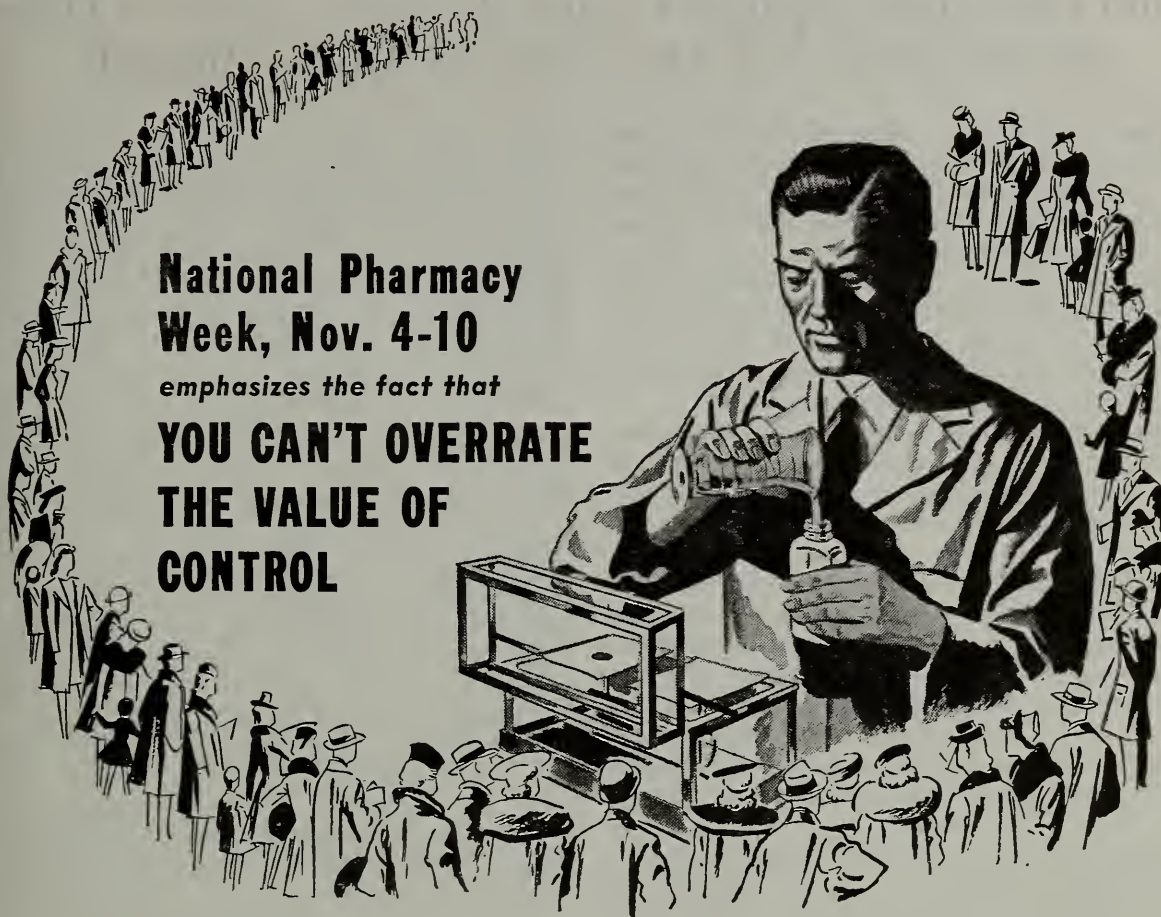
This announcement should receive the hearty approval of members of the medical profession who realize the abuses and dangers which have arisen because of a lack of proper legislation and regulation pertaining to the promiscuous use and distribution of hypnotic drugs.

This has become a growing problem in Ohio. Vigorous steps to find a solution are indicated. In our opinion the physicians of Ohio will give their active assistance and cooperation to any move which may be taken to bring about proper regulation in this state. It would be well for the medical and pharmaceutical professions to join in doing the planning for such regulation and take the initiative in having the necessary laws and regulations enacted. The national groups have started the ball rolling. It is up to the various states, including Ohio, to take over when appropriate methods have been devised.

### Health Commissioners Meet

The Twenty-Sixth Annual Conference of Ohio Health Commissioners was held at the Deshler-Wallick Hotel, Columbus, Sept. 28, with Dr. Roger E. Heering, State Director of Health, presiding. Speakers included: Dr. Samuel R. Damon, director, Bureau of Laboratories, Alabama State Department of Health, "The Present Status of Rabies"; Dr. Franklin Top, director, Division of Communicable Diseases and Epidemiology, Detroit Department of Health, "Recent Progress in the Control of Communicable Diseases", with discussion led by Dr. Carl A. Wilzbach, health commissioner of Cincinnati. The conference concluded with remarks concerning specific programs by chiefs of the various divisions of the State Department of Health.





## National Pharmacy Week, Nov. 4-10

*emphasizes the fact that*

# YOU CAN'T OVERRATE THE VALUE OF CONTROL

**N**owhere is the principle of *control* better appreciated or more carefully exercised than by our country's pharmacists. National Pharmacy Week gives us this opportunity to express recognition and acclaim of the members of this exacting ethical profession . . . for their years of specialized study and training — their devotion to accuracy — their service in public health.

- Translating physicians' orders into finished formulae is a responsibility highly valued and solemnly regarded by more than 10,000 skilled pharmacists in conveniently located Rexall Drug Stores throughout the land.
- Your very own neighborhood offers the broad, dependable service of one of these Rexall Drug Stores. Here your orders are competently filled with finest ingredients — outstanding among which are U. D. pharmaceuticals, famous for the quality control which insures their unvarying purity and potency.

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# Ohio Physicians Separated From the Army, Navy or Other Services Since V-E Day; Lists To Appear Monthly

**T**HE JOURNAL each month will make an effort to keep its readers informed of Ohio physicians separated from the Army, Navy or other wartime services or who are on terminal leave, pending separation.

The names of 177 Ohio medical officers separated from the services since V-E Day, or who are now on terminal leave and will be placed on an inactive status soon, are appended. Additional names will be published monthly.

The cooperation of medical officers themselves or their relatives and friends in making the list as complete as possible is solicited. Send this information to the State Association's Columbus office.

In the following tabulation, the city in which the medical officer resided and practiced when he entered the service is given in most instances. If the physician has changed location and this information is known, the place of relocation also is indicated. The rank shown is based on the latest data in the files of the Ohio State Medical Association which, of course, may not be entirely accurate in a few cases.

| NAME                  | CITY             | RANK                      |
|-----------------------|------------------|---------------------------|
| Althoff, Wm. R.       | Dayton           | Major, A.U.S.             |
| Astler, DeWitt G.     | Cincinnati       | Capt., A.U.S.             |
| Baird, Warren A.      | Toledo           | Major, A.U.S.             |
| Beale, Allen W.       | Warren           | Capt., A.U.S.             |
| Beare, Ralph J.       | Celina           | Surg., U.S.P.H.S.R.       |
| Beck, Claude S.       | Cleveland        | Col., A.U.S.              |
| Beeson, Harold G.     | Wooster          | Major, A.U.S.             |
| Berlesky, Harry S.    | Barberton        | Capt., A.U.S.             |
| Black, Marion E.      | Cleveland        | Capt., A.U.S.             |
| Blagdon, Jos. C.      | Cleveland        | Lt. Comdr., U.S.N.R.      |
| Blinn, John C.        | New Philadelphia | Lt. Col., A.U.S.          |
| Boukalik, W. F.       | Shaker Hts.      | Lt. Col., A.U.S.          |
| Bratten, Paul C.      | Sidney           | Capt., A.U.S.             |
| Bremen, Harry         | Dayton           | Major, A.U.S.             |
| Bresin, Bernard P.    | Cleveland        | Asst. Surg., U.S.P.H.S.R. |
| Brickman, Edward M.   | Cleveland        | Major, A.U.S.             |
| Brinker, Herbert J.   | Cincinnati       | Major, A.U.S.             |
| Brown, Henry A.       | Chillicothe      | P.A.S., U.S.P.H.S.R.      |
| Brown, John E., Jr.   | Columbus         | Major, A.U.S.             |
| Bunin, Simon          | Cleveland        | Capt., A.U.S.             |
| Campbell, Ivor M.     | Akron            | Major, A.U.S.             |
| Carlisle, Richard C.  | Columbus         | Major, A.U.S.             |
| Carter, B. N.         | Cincinnati       | Col., A.U.S.              |
| Caton, Russell J.     | Bucyrus          | Col., A.U.S.              |
| Clement, Fredk.       | Toledo           | Major, A.U.S.             |
| Compton, Wm. C.       | Cincinnati       | Major, A.U.S.             |
| Cook, Malcolm O.      | Hamilton         | Major, A.U.S.             |
| Cross, Theo. A.       | Cleveland        | Major, A.U.S.             |
| Cunningham, Walter A. | Steubenville     | Major, A.U.S.             |
| Curran, Thos. R.      | Columbus         | Major, A.U.S.             |
| Daniel, Walter A.     | Tiffin           | Capt., A.U.S.             |
| Darrah, D. C.         | Cleveland        | Capt., A.U.S.             |
| Davin, W. A.          | Hamilton         | Major, A.U.S.             |
| Dix, Carr E.          | Columbus         | Major, A.U.S.             |
| Dobkin, Arthur        | Akron            | Major, A.U.S.             |
| Donath, Stephen       | Toledo           | Capt., A.U.S.             |
| Dorr, Hugh C.         | Columbus         | Capt., A.U.S.             |
| Edelstein, J. B.      | Toledo           | Major, A.U.S.             |
| Fawcett, J. T.        | Elyria           | Major, A.U.S.             |
| Fink, Jos. J.         | Cleveland        | Capt., A.U.S.             |
| Fishman, David        | Cleveland        | Capt., A.U.S.             |
| Forrester, Jos. C.    | Columbus         | Major, A.U.S.             |
| Fowler, Hudson D.     | Cleveland        | P.A.S., U.S.P.H.S.R.      |
| Frankmann, R. W.      | Massillon        | Capt., A.U.S.             |
| Frye, C. M.           | Newark           | Capt., A.U.S.             |
| Galbreath, Walter F.  | Findlay          | Major, A.U.S.             |
| Gallen, John J.       | Columbus         | Major, A.U.S.             |
| Gardner, J. Stanley   | Cleveland        | Comdr., U.S.N.R.          |
| Geiss, Ferdinand V.   | Cleveland        | Capt., A.U.S.             |
| Gerspacher, T. S.     | Cleveland        | P.A.S., U.S.P.H.S.R.      |
| Gettman, R. L.        | Marion           | Major, A.U.S.             |
| Giannestras, N. J.    | Cincinnati       | Major, A.U.S.             |

| NAME                     | CITY              | RANK                      |
|--------------------------|-------------------|---------------------------|
| Gibbons, John T.         | Celina            | Major, A.U.S.             |
| Gordon, Nathan G.        | Akron             | Capt., A.U.S.             |
| Griner, Ned B.           | Circleville       | Asst. Surg., U.S.P.H.S.R. |
| Grogan, Francis R.       | Urbana            | Major, A.U.S.             |
| Guarnieri, Frank G.      | Warren            | Capt., A.U.S.             |
| Guilford, F. R.          | Columbus          | Major, A.U.S.             |
| Hagen, John S. Jr.       | Cincinnati        | Major, A.U.S.             |
| Hamann, Carl A.          | Cleveland         | Capt., A.U.S.             |
| Hanger, Irwin C.         | Cleveland         | Major, A.U.S.             |
| Harrison, Francis R.     | E. Liverpool      | Capt., A.U.S.             |
| Hattenbach, J. F.        | Cleveland         | Capt., A.U.S.             |
| Hauser, John W.          | Cincinnati        | Capt., A.U.S.             |
| Hawk, O. L.              | E. Cleveland      | Capt., A.U.S.             |
| Heimann, Jos. V.         | Lakewood          | Capt., A.U.S.             |
| Hill, Frank R.           | Cleveland Heights | Capt., A.U.S.             |
| Hilsinger, E. A.         | Cincinnati        | Surg., U.S.P.H.S.R.       |
| Houghton, Ben C.         | Columbus          | Lt. Col., A.U.S.          |
| Hudson, E. H.            | Athens            | Comdr., U.S.N.R.          |
| Humel, E. J.             | Cleveland         | Major, A.U.S.             |
| Humphries, John K.       | Belle Center      | Major, A.U.S.             |
| Jacobs, R. B.            | Dayton            | Capt., A.U.S.             |
| Jacoby, G. W., Jr.       | Wooster           | Asst. Surg., U.S.P.H.S.R. |
| Jennings, Wm. M., Jr.    | Sylvania          | Major, A.U.S.             |
| Joelson, James J.        | Cleveland         | Major, A.U.S.             |
| Junkerman, Carl S.       | Columbus          | Lt. Col., A.U.S.          |
| Keating, Edw. T.         | Hamilton          | Capt., A.U.S.             |
| Keating, Robt. A.        | Columbus          | Lt., U.S.N.R.             |
| Kechele, O. J.           | Berea             | Major, A.U.S.             |
| Kerns, Henri A.          | Kenton            | Capt., A.U.S.             |
| Keyes, John E. L.        | Youngstown        | Lt. Col., A.U.S.          |
| King, George L., Jr.     | Alliance          | Lt. Col., A.U.S.          |
| Klatman, Samuel J.       | Youngstown        | Capt., A.U.S.             |
| Kling, Herman A.         | Youngstown        | Capt., A.U.S.             |
| Kocour, James L.         | Cleveland         | Capt., A.U.S.             |
| Kolb, T. V.              | Litchfield        | Major, A.U.S.             |
| (formerly S. Charleston) |                   |                           |
| Kuehn, A. J.             | Toledo            | Major, A.U.S.             |
| Kuntz, Wm. M.            | Millersport       | Capt., A.U.S.             |
| Lacock, Wilford C.       | Beaverdam         | Major, A.U.S.             |
| Landen, C. C.            | Columbus          | Capt., A.U.S.             |
| Lazzari, J. H.           | Cleveland         | Lt. Col., A.U.S.          |
| Light, T. L.             | Dayton            | Capt., A.U.S.             |
| Lindenmeyer, A. P.       | Ashtabula         | Capt., A.U.S.             |
| (formerly Cleveland)     |                   |                           |
| Long, H. A.              | Hamilton          | Capt., A.U.S.             |
| Lord, S. N.              | Somerset          | Capt., A.U.S.             |
| Lovebury, Wm. F.         | Columbus          | Lt. Col., A.U.S.          |
| Martin, John E.          | Bexley            | Major, A.U.S.             |
| McAfee, James P.         | Portsmouth        | Capt., A.U.S.             |
| McCammon, F. A.          | Van Wert          | Major, A.U.S.             |
| Mansfield, R. D.         | Canton            | Major, A.U.S.             |
| Marquart, J. R.          | Springfield       | Capt., A.U.S.             |
| Marshall, J. H.          | Findlay           | Lt. Col., A.U.S.          |
| Mattocks, T. R.          | Marietta          | Capt., A.U.S.             |
| Meany Frank L.           | Lakewood          | Major, A.U.S.             |
| Meckstroth, Paul G.      | New Knoxville     | Major, A.U.S.             |
| Merrill, W. B.           | Columbus          | Major, A.U.S.             |
| Meyers, R. D.            | Columbus          | Capt., A.U.S.             |
| Miller, Noah             | Akron             | Capt., A.U.S.             |
| Mills, A. M.             | Ashtabula         | Capt., A.U.S.             |
| Minning, Carl A.         | Williamsburg      | Capt., A.U.S.             |
| Missal, Sylvester C.     | Cleveland         | Col., A.U.S.              |
| Montgomery, E. L.        | Cleveland         | Major, A.U.S.             |
| (formerly Circleville)   |                   |                           |
| Namen, Jay M.            | Cleveland Heights | Major, A.U.S.             |
| Northrup, C. E., II      | McConnellsville   | Major, A.U.S.             |
| Ockington, James W.      | Lakewood          | Major, A.U.S.             |
| Ockuly, Eugene A.        | Toledo            | Major, A.U.S.             |
| Paley, Aaron             | Cleveland         | Capt., A.U.S.             |
| Palmer, G. A.            | Akron             | Major, A.U.S.             |
| Parsons, Grant E.        | Cleveland         | P.A.S., U.S.P.H.S.R.      |
| Patton, Thomas E.        | N. Jackson        | Major, A.U.S.             |
| Peebles, T. A.           | Lorain            | Major, A.U.S.             |
| Perry, Claude S.         | Columbus          | Lt. Col., A.U.S.          |
| Pilloff, Benj.           | Uhrichsville      | Capt., A.U.S.             |
| Pollack, David           | Columbus          | Capt., A.U.S.             |
| Pritchett, Clark         | Columbus          | Major, A.U.S.             |
| Prochaska, C. J.         | South Euclid      | Lt. Col., A.U.S.          |
| Rayman, J. B.            | Toledo            | Capt., A.U.S.             |
| Rice, Milo B.            | Pandora           | Major, A.U.S.             |
| Ridgevav, Jos. A.        | Columbus          | Lt. Col., A.U.S.          |
| Riebel, John A., II      | Ashland           | Capt., A.U.S.             |
| Rodabaugh, G. S.         | Basil             | Capt., A.U.S.             |
| Rodenberg, Elmer J.      | Columbus          | Lt. Col., A.U.S.          |
| Roller, Jay P.           | Luckey            | Major, A.U.S.             |
| Runnels, Scott C.        | Cleveland         | Col., A.U.S.              |
| Rusoff, M. B.            | Columbus          | Capt., A.U.S.             |
| Russell, Wm. E.          | Genoa             | Capt., A.U.S.             |
| Sanders, E. W.           | Bellevue          | Capt., A.U.S.             |
| Schumacher, E. R.        | Columbus          | Major, A.U.S.             |
| Scott, John M.           | Canton            | Major, A.U.S.             |
| Shepard, Jos. H.         | Columbus          | Capt., A.U.S.             |



| NAME                  | CITY                | RANK                 |
|-----------------------|---------------------|----------------------|
| Sherman, M. L.        | Dayton.....         | Major, A.U.S.        |
| Shilling, Ralph H.    | Columbus.....       | Lt. Col., A.U.S.     |
| Shilling, R. L.       | Ashland.....        | Capt., A.U.S.        |
| Sisek, Henry          | Youngstown.....     | Capt., A.U.S.        |
| Slusher, Robt. G.     | St. Henry.....      | Capt., A.U.S.        |
| Smith, E. McCall      | Dayton.....         | Lt. Comdr., U.S.N.R. |
| Smith, F. A.          | Akron.....          | Comdr., U.S.N.R.     |
| Smith, Herman C.      | Cleveland.....      | Lt. Col., A.U.S.     |
| Smith, Merl B.        | Toledo.....         | Capt., A.U.S.        |
| Smith, Robert J.      | Cleveland.....      | Capt., A.U.S.        |
| Stelzner, Glenn W.    | Newcomerstown.....  | Capt., A.U.S.        |
| Sternberg, Elmer G.   | Cincinnati.....     | Capt., A.U.S.        |
| Stuhlman, B. C.       | Dayton.....         | Capt., A.U.S.        |
| Suhay, Paul L.        | Cleveland.....      | Capt., A.U.S.        |
| Swango, J. D.         | Waterloo.....       | Capt., A.U.S.        |
| Szucs, M. M.          | Youngstown.....     | P.A.S., U.S.P.H.R.S. |
| Tapke, Robert J.      | Cincinnati.....     | Major, A.U.S.        |
| Taylor, David J.      | Yellow Springs..... | Major, A.U.S.        |
| Tims, Walter J.       | Youngstown.....     | Major, A.U.S.        |
| Tingwald, Fred L.     | Youngstown.....     | Capt., A.U.S.        |
| Todd, Oliver E.       | Toledo.....         | Major, A.U.S.        |
| Toth, D. F.           | Cleveland.....      | Major, A.U.S.        |
| Urban, John P.        | Columbus.....       | Capt., A.U.S.        |
| Urbanski, Walter J.   | Cleveland.....      | Capt., A.U.S.        |
| Wagner, Gordon        | E. Cleveland.....   | Capt., A.U.S.        |
| Wahl, Robert H.       | Dayton.....         | 1st Lt., A.U.S.      |
| Wedemeyer, Marlin R.  | Oak Hill.....       | Capt., A.U.S.        |
| Welch, Brent A.       | Columbus.....       | Major, A.U.S.        |
|                       | (formerly Sidney)   |                      |
| Werle, J. M.          | Cleveland.....      | Capt., A.U.S.        |
| Wertheimer, Jerome I. | Painesville.....    | Capt., A.U.S.        |
| Williard, Nicholas    | Tiffin.....         | Capt., A.U.S.        |
| Wood, Cyrus R.        | Port Clinton.....   | Lt. Col., A.U.S.     |
| Zeno, Ross R.         | Akron.....          | Capt., A.U.S.        |
| Zeve, Herman S.       | Youngstown.....     | Comdr., U.S.N.R.     |
| Ziskind, J. A.        | Columbus.....       | Capt., A.U.S.        |

### Advisory Committee To Child Hygiene Division Is Appointed

An Advisory Committee to the Division of Child Hygiene, Ohio Department of Health, has been appointed by Dr. Roger Heering, State Director of Health, following consultation with The Council of the Ohio State Medical Association.

Those appointed were: Dr. James G. Kramer, Akron; Dr. Robert A. Lyon, Cincinnati; Dr. L. E. Leavenworth, Canton; Dr. Dana Cox, Columbus; Dr. John A. McNamara, Marion, and Dr. H. D. Chamberlain, McArthur.

The committee will act in an advisory capacity to the Division, of which Dr. Susan P. Souther is director, on matters of policy and procedure in the operation of the department's maternal and child hygiene programs.

The first meeting of the Advisory Committee will be held on November 7 in Columbus.

### Conference on Tuberculosis

A conference on "Control of Tuberculosis in a Metropolitan Area", will be held at the Palmer House, Chicago, Nov. 13-14, by The Institute of Medicine of Chicago, in association with the Chicago Medical Society, The Tuberculosis Institute of Chicago and Cook County, Council of Social Agencies of Chicago and the Chicago Tuberculosis Society. Many outstanding men in this field appear on the program, which is devoted to phases of tuberculosis which are of particular importance to clinicians, specialists, lay workers and interested citizens. Programs and registration cards can be obtained by addressing the Institute of Medicine of Chicago, 86 East Randolph St., Chicago 1.

### Dr. Doull To Head International Health Relations for U. S.

Dr. James A. Doull, Elisabeth Severance Prentiss professor of public health in the School of Medicine, Western Reserve University, has resigned, effective March 31, 1946, to join the Regular Corps of the United States Public Health Service, in charge of International Health Relations in the Office of the Surgeon General.

The resignation vacates the chair in public health established recently in the School of Medicine by the university with the support of a bequest of the late Mrs. Elisabeth Severance Prentiss. Dr. Doull had previously been head of the Department of Hygiene and Bacteriology, now divided into the Department of Public Health and the Department of Microbiology. Headships of both departments will now be filled.

A member of the Ohio State Medical Association and a Fellow of the American Medical Association, Dr. Doull has been at Western Reserve University since 1930 coming there from Johns Hopkins University. He is widely known for his epidemiological studies, especially in diphtheria, leprosy and tuberculosis. He has been a member of the Advisory Board of the Division of Health, Vice-Chairman of the Cleveland Health Council, Chairman of the Advisory Council of the Cleveland Health Museum and President of the Hearing and Speech Center. For two years he was President of the Cleveland Child Health Association.

On the national level he is a member of the Executive Committee and Council of the American Public Health Association and a member of the Advisory Medical Board of the American Leprosy Foundation.

Dr. Doull had three foreign assignments during the war. The first was a special mission to the Pacific for the Lend Lease Administration to Australia and New Zealand to obtain urgently necessary supplies. The second was to England for the United Nations Relief and Rehabilitation Administration. The third was to Europe with regard to preliminary arrangements for the proposed international health organization. He attended the San Francisco Conference as an assistant to the United States Delegation.

Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*, Columbus, has been appointed associate editor of *Geriatrics*, official journal of The American Geriatric Society. Also on the staff are: Dr. Walter E. Vest, Huntington, W. Va., editor, *West Virginia Medical Journal*; Dr. Wingate M. Johnson, Winston-Salem, N. C., editor, *North Carolina Medical Journal*, and Dr. Solon M. White, Minneapolis, emeritus professor of medicine, University of Minnesota Medical School.

# Industrial Commission Disbursed \$3,412,675 For Medical Services During 1944, Report of Actuary Reveals

**T**HE Industrial Commission of Ohio disbursed \$3,412,675.60 for medical services to injured Ohio workmen during 1944, according to a recent report of H. H. Pickering, Supervising Actuary. Included in that figure is a relatively small amount for dental services.

Other expenditures during the year included \$1,914,454.49, hospital care and nursing; \$123,611.99, funeral expenses, and \$67,332.68, court costs, a total of \$5,518,074.76.

These amounts include payments covering treatment of injured private and public employees as well as similar costs on occupational diseases, and are in addition to death awards and compensation to injured workmen.

Comparative figures for 1943 were as follows: \$3,457,727.45, medical services; \$1,801,325.00, hospital care and nursing; \$130,821.34, funeral expenses, and \$97,001.18, court costs, a total of \$5,486,874.97.

## SLIGHT DECREASE IN CLAIMS

The number of claims filed during 1944 was 285,891, or 14 per cent under the number for the year 1943. There were 331,072 claims filed in 1943, the peak year in the 33-year history of the Ohio Workmen's Compensation Fund. The total for 1932, during the depression, was 130,099.

"Medical only" claims, involving payment for physicians' services but no compensation to the claimant for loss of time, numbered 217,450 in 1944, or 76 per cent of all claims filed, compared with 79 per cent in 1943. The average fee of "medical only" claims increased from \$7.88 in 1943 to \$7.89 in 1944.

## STATUS OF THE FUND

Included with the actuary's report is a statement of the financial condition of the Ohio State Insurance Fund as of December 31, 1944. (Table 1).

During the year 1944 there was an increase of \$4,225,515.36, resulting in a total surplus of \$15,175,386.27. The total assets reached the highest peak in the history of the Fund, increasing during the year in the amount of \$13,324,359.47 to a total of \$134,401,581.07.

The claim reserve established to meet future payments of benefits was increased over that of 1943 by \$8,949,829.24, making a total claim reserve of \$99,613,125.33. The report points out that the increased number of claims which have been filed in the past few years will continue to have an adverse effect, necessitating the establishment of sufficient reserves to meet the additional cost.

Following are some important excerpts from the Actuary's report for 1944:

## RATES

"This year's revision of rates has experienced an increase of 2.6 per cent over the general level of last year. Several factors have entered into the increase, chief of which is the pending legislation to increase benefits to injured workers. The enactment of Senate Bill No. 211 will provide for an increase in weekly benefits to \$24.50 maximum, \$10.00 minimum, and a death benefit of \$7,500. The effect of this increase in benefits will require the assessment of additional premium to employers to meet future claim costs.

"Another bill pending is designed to provide incentive for employers to hire disabled war veterans. The provisions of this bill will serve as a further drain on the Ohio Workmen's Compensation Fund in the event of a second injury to the disabled veteran in that the employer will be affected in his experience only by the cost of the second injury, while the Ohio Fund will have to bear all additional cost. No legislative provision has been made to provide for this additional cost.

"Analyzing Table 2, it is shown that all of the items in 1944 except the percentage losses to premium and expense items are 45 per cent or greater than the corresponding items for the year 1940. This discloses that the per cent of losses to premium having increased from 82.5 per cent to 85.9 per cent is an important factor in justifying the slight increase in the current level of rates. The item captioned Expense represents a portion of the premium expended for maintenance of the Division of Safety and Hygiene and audit of the Fund but no part of this item includes general administration expense.

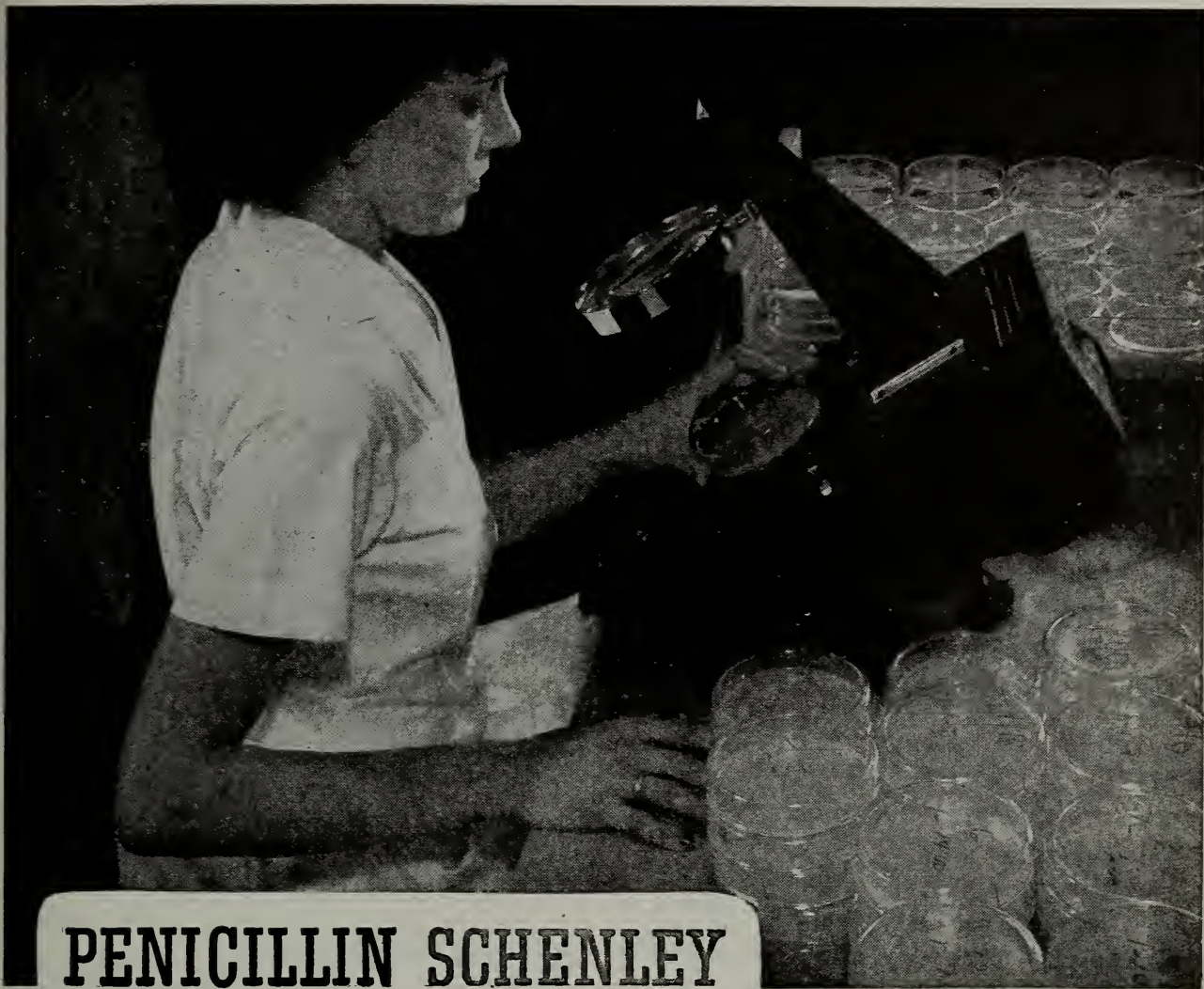
## CURRENT DISBURSEMENTS

"Table 3 discloses the current disbursements that have been paid for active claims distributed according to year of injury and having injury dates in some instances reaching back to the beginning of the Fund. In addition to these disbursements, there has been a reserve of \$99,613,125.33 established to meet benefit payments over many years in the future.

"The compensation benefit disbursements in the amount of \$13,519,498 paid to injured workers or their dependents represented 75.2 per cent of the total disbursements, and medical, burial and court costs in the amount of \$4,452,948 represented 24.8 per cent of the total disbursements of \$17,972,437.

"The percentage of the total paid on current





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The penicillin which first attracted the attention of Alexander Fleming was an "occurrence of nature", with no control exercised over the conditions of its production. Production of pyrogen-free penicillin for the medical profession, however, is accomplished only by the most elaborate methods of control for insuring highest attainable productivity, potency, and purity.

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TABLE 1  
OHIO STATE INSURANCE FUND  
(Workmen's Compensation)  
FINANCIAL STATEMENT AS OF DECEMBER 31, 1944  
\*PRIVATE FUND

| ASSETS                                                                                                                                                                                                           |                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| BONDS AT AMORTIZED VALUES.....                                                                                                                                                                                   | \$129,585,526.42 |
| State Treasurer's Bond Balance.....                                                                                                                                                                              | \$135,834,149.16 |
| *Less Public Fund.....                                                                                                                                                                                           | 7,684,424.59     |
| Par value of bonds.....                                                                                                                                                                                          | \$128,149,724.57 |
| Amortized value over par.....                                                                                                                                                                                    | 1,435,801.85     |
| All bonds are in the custody of the State Treasurer and consist of obligations of the Federal Government and Ohio taxing districts.                                                                              |                  |
| CASH .....                                                                                                                                                                                                       | 1,339,052.51     |
| (Deposited with State Treasurer as Custodian)                                                                                                                                                                    |                  |
| State Treasurer's Balance.....                                                                                                                                                                                   | \$1,503,415.38   |
| *Less Public Fund.....                                                                                                                                                                                           | 164,362.87       |
| PREMIUMS IN COURSE OF COLLECTION.....                                                                                                                                                                            | 2,782,734.54     |
| (Less reserve for doubtful accounts)                                                                                                                                                                             |                  |
| INTEREST ACCRUED .....                                                                                                                                                                                           | 694,267.60       |
| TOTAL ASSETS .....                                                                                                                                                                                               | \$134,401,581.07 |
| *The Ohio State Insurance Fund is separated by statute into two funds. The Private Fund covers employers in private industry, while the Public Fund covers the State, municipalities and other taxing districts. |                  |
| LIABILITIES                                                                                                                                                                                                      |                  |
| RESERVE FOR COMPENSATION AND MEDICAL BENEFITS.....                                                                                                                                                               | \$ 99,613,125.33 |
| Reserve involved in merit rating.....                                                                                                                                                                            | \$44,391,200.00  |
| Reserve not involved in merit rating.....                                                                                                                                                                        | 55,221,925.33    |
| RESERVE FOR CONTINGENCIES .....                                                                                                                                                                                  | 8,960,098.42     |
| To provide for possible depreciation of investments and other contingencies.                                                                                                                                     |                  |
| OUTSTANDING WARRANTS .....                                                                                                                                                                                       | 1,820,782.29     |
| Warrants issued which had not been presented for payment to the State Treasurer by December 31, 1944.                                                                                                            |                  |
| UNEARNED PREMIUMS .....                                                                                                                                                                                          | 8,832,188.76     |
| That portion of Advance Premium paid for coverage beyond December 31, 1944.                                                                                                                                      |                  |
| SURPLUS .....                                                                                                                                                                                                    | 15,175,386.27    |
| TOTAL LIABILITIES AND SURPLUS.....                                                                                                                                                                               | \$134,401,581.07 |

TABLE 2  
COMPARATIVE INCOME, LOSSES AND EXPENSE

| Year       | Earned Premium | Losses Incurred | Minus Investment Earnings | Net Losses Incurred | % Losses to Premium | Expense   |
|------------|----------------|-----------------|---------------------------|---------------------|---------------------|-----------|
| 1940 ..... | \$18,124,819   | \$19,380,332    | \$1,881,310               | \$17,499,022        | 96.5                | \$143,935 |
| 1941 ..... | 25,323,544     | 22,650,750      | 1,877,703                 | 20,775,047          | 82.0                | 154,573   |
| 1942 ..... | 32,264,595     | 31,835,609      | 2,189,318                 | 29,646,291          | 91.9                | 158,923   |
| 1943 ..... | 33,360,118     | 30,193,423      | 2,667,109                 | 27,526,314          | 82.5                | 179,959   |
| 1944 ..... | 29,584,362     | 28,547,686      | 3,124,119                 | 25,423,567          | 85.9                | 191,451   |

injuries in 1943 for compensation and medical benefits combined amounted to 44.7 per cent of the total disbursements, while in 1944 the disbursements on injuries in the current year amounted to only 35.9 per cent, a decrease of 8.8 per cent. This decrease is offset by the increase of the cost of second and third year injury claims.

CLAIM COST

"Accident claims for 1944 developed the same average cost per claim as in 1943. The compensation cost increased 2 per cent while the medical cost decreased 6 per cent. This is an indication

of a reversal in trend of accident costs upward due largely to the claim cost advancing to meet war time efforts.

"The occupational disease portion of the Fund during the year 1944 passed from a prior deficit of \$772,490.36 to a surplus of \$354,906.51, which justified substantial reductions in occupational disease rates for many industries.

THIRTY-THREE YEAR RECORD

"On March 1, 1945 the Ohio State Insurance Fund reached its 33rd anniversary as a state-





*Not Merely*  
**ISOLATED NUTRIENTS**

Essential though they are, vitamins are nevertheless not the only nutrients which may be lacking in the diet of persons physically below par. Nutritional imbalance, not infrequently the cause of poor physical stamina, excessive irritability, and poor appetite, may be attributable to other dietary-induced deficiencies. In consequence, adjustment of the entire nutritional intake is indicated.

Virtually any diet can be enhanced to a point of adequacy through the addition of three glassfuls of Ovaltine daily. Made with milk as

directed, this delicious food drink supplies liberal quantities of most essential nutrients, as indicated by the table below. Qualitatively Ovaltine is equally valuable; it provides biologically adequate protein, readily assimilated and utilized carbohydrate, well emulsified fat, B complex and other vitamins, as well as essential minerals. Ovaltine proves advantageous both as a mealtime beverage and a between-meal snack. Its low curd tension insures rapid gastric emptying, hence it does not interfere with the appetite for the next meal.

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*Ovaltine*

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|------------------------|-----------|----------------------|-----------|
| PROTEIN . . . . .      | 31.2 Gm.  | VITAMIN A . . . . .  | 2953 I.U. |
| CARBOHYDRATE . . . . . | 62.43 Gm. | VITAMIN D . . . . .  | 480 I.U.  |
| FAT . . . . .          | 29.34 Gm. | THIAMINE . . . . .   | 1.296 mg. |
| CALCIUM . . . . .      | 1.104 Gm. | RIBOFLAVIN . . . . . | 1.278 mg. |
| PHOSPHORUS . . . . .   | .903 Gm.  | NIACIN . . . . .     | 7.0 mg.   |
| IRON . . . . .         | 11.94 mg. | COPPER . . . . .     | .5 mg.    |

\*Based on average reported values for milk.



operated workmen's compensation carrier for Ohio employers.

"For the first year and ten months the Fund operated in competition with private insurance companies, and for the last 31 years has been operated as an exclusive fund in that private

**TABLE 3**

**1944 BENEFIT DISBURSEMENTS DISTRIBUTED TO YEAR OF INJURY OCCURRENCE**  
(Excludes Occupational Disease and Public Fund)

|                                        | Compensation | Medical, Hospital and Other Costs | Total        | Per Cent |
|----------------------------------------|--------------|-----------------------------------|--------------|----------|
| Total in 1944 for all years' accidents | \$13,519,489 | \$4,452,948                       | \$17,972,437 | 100.0    |
| 1944 ...                               | 3,682,807    | 2,776,779                         | 6,459,586    | 35.9     |
| 1943 ...                               | 2,618,504    | 922,776                           | 3,541,280    | 19.7     |
| 1942 ...                               | 1,815,927    | 289,028                           | 2,104,955    | 11.7     |
| 1941 ...                               | 1,086,168    | 140,779                           | 1,226,947    | 6.8      |
| 1940 ...                               | 761,660      | 75,922                            | 837,582      | 4.7      |
| 1939 ...                               | 432,969      | 32,786                            | 465,755      | 2.6      |
| 1938 ...                               | 417,225      | 25,320                            | 442,545      | 2.5      |
| 1937 ...                               | 427,156      | 20,806                            | 447,962      | 2.5      |
| 1936 ...                               | 240,051      | 21,375                            | 261,424      | 1.5      |
| 1935 ...                               | 161,834      | 15,590                            | 177,424      | 0.9      |
| 1912-1934                              | 1,875,188    | 131,789                           | 2,006,977    | 11.2     |
| Total ..                               | \$13,519,489 | \$4,452,948                       | \$17,972,437 | 100.0    |
| Ratios                                 | 75.2         | 24.8                              | 100.0        |          |

insurance companies have been prohibited from writing workmen's compensation insurance in Ohio.

"The record as to the accomplishments of the Fund for March 1, 1912 to December 31, 1944 is as follows:

|                          |                   |
|--------------------------|-------------------|
| Employers insured .....  | 173,379 (a)       |
| Premium collected .....  | \$459,790,701     |
| Benefits disbursed ..... | \$377,403,731     |
| Interest collected ..... | \$ 55,877,895 (b) |
| Claims filed .....       | 5,849,778         |

(a) Number of employers insured at some period or continuously over the 33 years.

(b) Interest earned on Fund investments used to pay benefits, thus obviating the necessity for premium in like amount.

**RECENT YEARS GROWTH**

| Year | Employers Insured | New Claims Filed | Assets        |
|------|-------------------|------------------|---------------|
| 1933 | 42,824            | 131,145          | \$ 40,167,624 |
| 1936 | 47,861            | 204,194          | 51,375,040    |
| 1939 | 51,861            | 183,180          | 67,856,966    |
| 1943 | 60,492            | 331,072          | 128,299,916   |
| 1944 | 63,107            | 285,891          | 142,307,697   |

"From the above it is disclosed that the assets of the Fund have shown a consistent growth since the year 1933 from \$40,167,624 to \$142,307,697.

"The number of new claims filed reached their peak in the year 1943 and during 1944 declined to the extent of 45,181. This is a strong indication of a greater trend toward employment stabilization with better accident prevention control."

## Payment To Physicians for Furnishing Affidavits To Commission Is Rescinded; Funds Lacking

When the Ohio Industrial Commission adopted a revised Medical and Surgical Fee Schedule, effective last May 1, it provided for a fee of \$3.00 for "affidavits furnished by physicians upon request of the Commission containing information used as a basis for adjudication of the claim". This was done on recommendation of the Ohio State Medical Association.

This provision was rescinded by action of the Commission on October 15 and such revocation took effect on October 28.

All fee bills for furnishing such affidavits at the request of the Commission received and approved by the Commission prior to the rescinding of that section of the fee schedule will be paid but bills received after that date will be rejected.

According to members of the Commission, this action was necessary because of a combination of circumstances which left the Commission without resources to meet such payments.

It had been anticipated that such fees would be paid out of the funds from which compensation and medical, hospital and nursing expenses are paid, namely, the state insurance fund consisting of premiums paid by employers.

However, the Attorney General on July 19 ruled that a fee for affidavits could not be legally charged against the insurance fund but must be considered a part of administrative expenses.

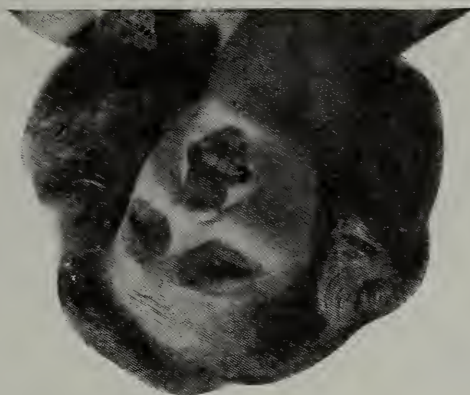
Funds for administrative expenses are appropriated by the State Legislature based on a budget submitted by the Commission. Since the Commission had made no provision in its budget for such payments from administrative funds, it found itself without sufficient money to pay for affidavits which might be requested during the biennium.

Finding itself without funds to pay the fee established in the fee schedule and not wishing to assume financial obligations which it could not meet, the Commission stated it had no recourse but to rescind that part of the fee schedule.

It has been suggested to the Commission that efforts be made to obtain permission of the Board of Control to transfer certain funds appropriated to the Commission for other functions or to request an emergency appropriation from the Board for this purpose.

This suggestion is being considered by members of the Commission who favor compensating physicians for the furnishing of such affidavits, providing a way can be worked out to supply the Commission with adequate funds to do so.



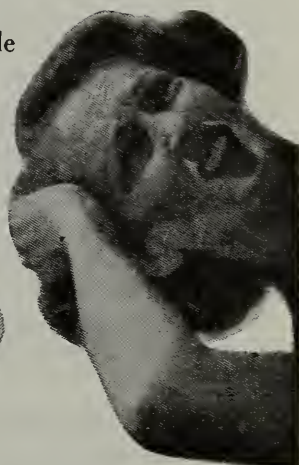


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'DELVINAL' *sodium vinbarbital* will provide  
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moderate duration of action. Undesirable  
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Council accepted. Supplied in  $\frac{1}{2}$  gr.,  
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*Sodium Vinbarbital*



# Medical Care Provisions of Ohio's Public Assistance Program Analyzed in Revised Division Manual

A DETAILED explanation of the regulations and policies of the Division of Social Administration, Ohio Welfare Department, relating to medical and hospital services for recipients of public assistance, including general relief, is set forth in a revised section, "Medical Care", of the Public Assistance Manual issued by the department.

Commenting on the revised section, Henry J. Robison, chief of the Division of Social Administration, stated that the section is designed to place the medical aspects of the poor relief program on a fee basis, thus resulting in payment to physicians, dentists and clinics for services actually performed. Judge Robison also pointed out that the local expenditures of poor relief areas are eligible for matching by the state when the record shows conclusively that eligibility has been established and that this applies to all types of cases, including those to which medical care only has been given.

Following are pertinent excerpts of the revised section on "Medical Care", which should be read carefully by physicians and filed for reference when rendering services to recipients of public assistance or those eligible to apply for assistance:

## GENERAL STATEMENT

The responsibility for providing medical care to needy individuals in Ohio is divided among several agencies. For some services there is overlapping of authority or responsibility. In this maze, it is possible for the sick to be left without necessary services, unless each public assistance agency accepts its responsibility to provide care to the limit of its authority, or to secure the cooperation of another agency which is also able and willing to provide the care.

Poor relief areas, administered by county or city administration, are the basic agencies for providing medical care. However, it is necessary to understand what other public agencies are empowered to do. Aid for the Aged, Aid to Dependent Children, and Aid to Blind have certain authority in relation to their recipients; township trustees and city officials have responsibilities for hospitalization; public health departments, public and private hospitals, clinics and other groups represent other resources for medical and hospital care.

## AID FOR AGED

The Division of Aid for Aged may provide medical care or hospitalization by including these items in the budgetary requirements of a recipient. Payments are subject to the same provisions in respect to restricted or conditional

payments as in the programs of Aid to Blind and Aid to Dependent Children. There is no provision for paying directly to physician or hospital. Other public agencies or officials are responsible for medical or hospital care when these requirements can not be met by the AFA grant.

## Health Care

The Division of Aid for the Aged includes in the budget of all recipients at least a minimum of \$12.00 per annum for medical needs even though the recipient is not under the care of a physician. This allowance is based on the statement of the recipient and may be increased to \$24.00 maximum in accordance with the verification of the amounts of medication and supplies used.

## Medical Care

When the recipient has specific ailments and is under the care of a physician the allowance in the budget is based on the physician's diagnosis and recommendation as to the estimated number of professional calls, either to the home or by recipient to the office, and the cost of medicine prescribed per month.

If the health condition changes, the award is subject to re-investigation and adjustment at any time. When an emergency illness of a recipient has necessitated special care and a debt has been incurred, allowance for the payment may be planned by increasing the award to the maximum of \$40.00 a month for the given period of months necessary to cover it.

## Hospitalization

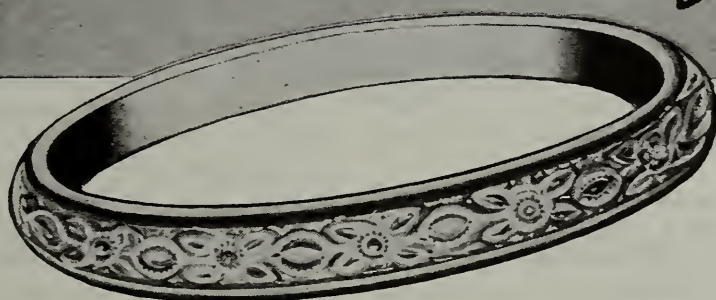
The award of a recipient may be increased to the maximum grant to enable him to pay toward his hospital cost a sum not to exceed \$40.00 a month for each calendar month or fraction thereof during which he is hospitalized, and during which the cost of such care equals or exceeds this amount.

In most cases the recipient must meet his usual living expenses during the time the hospital bill is being paid. In such cases the cost of hospital care is pro-rated over a period of time, the monthly payment to the hospital being represented by the difference between the amount required to meet necessary living expenses and the maximum grant of \$40.00. The increased award continues during the period of time necessary to enable the recipient to pay his share of the total hospital cost determined at a rate not to exceed \$40.00 a month.

An example would be the case of a recipient who is receiving an award of \$30.00 a month and who enters a hospital on January 20 and



# There is no *Universal Size*



**T**HERE never has been a wedding ring that would correctly fit the finger of all women . . . and there is no universal size of occlusive diaphragm that will correctly conform to the many variations of the vaginal and cervical structures.

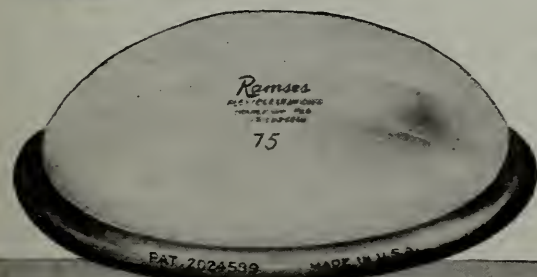
Competent clinical investigation has established that an occlusive diaphragm must be of individually correct size in order for the cervix to be properly protected against entrance of spermatozoa.

Because of the variance in the vaginal anatomy of individual patients the correct size can be determined only through measurement by a properly qualified physician.

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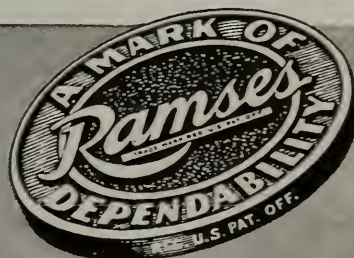
are made in gradations of 5 millimeters in sizes ranging from 50 to 95 millimeters inclusive . . . available through any recognized pharmacy.

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Gynecological Division  
**JULIUS SCHMID, INC.**

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remains there for 21 days until February 9. The total cost of hospital care is \$150.00. The period of hospitalization would extend over a period of time involving two calendar months (January and February), and therefore the share of the total cost which may be met from Aid for Aged funds is \$80.00, representing a \$40.00 payment for each calendar month. The amount should be placed in the budget and the award increased to \$40.00. As the ordinary living expenses of the recipient require an award of \$30.00 a month, the increase in the award to \$40.00 would enable the recipient to make a payment of \$10.00 a month on the hospital bill. The increase would be continued for eight months until the recipient's share of the total bill has been paid.

Because of the mechanical procedures necessary in the state AFA office and in the office of the Auditor of State, a minimum of six weeks is required before an increase in award actually affects the recipient's check.

Aid may be continued to an AFA recipient by the Division of Aid for the Aged for a limited period, usually less than ninety days, after he has entered a public hospital for temporary emergency care. Any extension of time beyond ninety days must have the approval of the Chief of the Division.

#### AID TO BLIND

Medical care for recipients of aid to blind may be provided in several ways. There are limitations on direct expenditures in the same way as on the aid for aged program.

##### Medical Eye Treatment

When the medical care is related to prevention of blindness or restoration of vision, the cost of service may be charged to the aid to blind fund. These services may include the physician's fee, the cost of hospitalization and other expenses incident to securing the services. The fees and hospitalization are paid from the special medical fund and are not subject to state or Federal matching. Applicants for medical care only must qualify for the program in the same way as applicants for assistance, i.e., they must meet the requirements of residence, age and need. In determining the extent of need, the resources of the applicant over and above minimum requirements as determined by standards of assistance should be considered available for part or all of the medical needs.

The usual procedure for providing this type of medical care is to work out arrangements in consultation with the nurse of the Ohio Commission for the Blind. When the eye examination is reviewed by the state ophthalmologist, he indicates whether surgical or medical treatment is recommended, by writing the letters "P.O.B." (Prevention of Blindness) in the upper right-

hand corner. The case is referred to the state nurse at the same time the copy of the examination is returned to the county office. The exact division of responsibility for carrying out plans for medical treatment is developed between the nurse and each county worker. The nurse is available for the following services: discussion with the patient of the need for and the possibilities of the operation; securing the patient's consent to the operation on the prescribed form; arranging with a skilled ophthalmologist to perform the operation, arranging for hospitalization, discussion with county officials and others about financing the operation.

Applications are sometimes received from recipients of AFA or from residents of the County Home. Persons who were receiving AFA in June, 1941, are ineligible for aid to the blind as are persons living in public institutions. Other recipients of AFA are eligible for medical assistance from aid to the blind, although they may not receive a money payment for basic maintenance in the same period as they receive one from AFA. The usual procedure of establishing eligibility is required, but most of the requirements may be verified quickly by the local AFA office.

#### Other Medical Provision

The cost of examinations for the recipient of aid to blind or for members of his family who are important to his health and well-being may be paid from the administration fund which is subject to Federal reimbursement. This provision also applies to the expenses incident to making medical care available, such as transportation. Otherwise there is no provision for paying the cost of medical service except through the monthly grant. This may be adjusted to a maximum of \$40.00 a month, by including in the requirements the amount which the recipient is expected to pay each month for medical service. For example, a recipient in need of an operation may arrange with his physician to pay \$10.00 a month for five months. In preparing the assistance plan, the worker includes \$10.00 as a special requirement and then determines the total grant by considering all of the requirements and all resources. While this method is quite satisfactory in cases involving predictable medical expense, it is difficult to use in cases of emergency treatment. It is also important to remember that the recipient can not be compelled to pay the \$10.00 allotted to the physician, but may only be informed that in determining his monthly payment, the requirements considered include this amount for medical care.

#### AID TO DEPENDENT CHILDREN

The aid to dependent children program offers three ways in which medical charges may be



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paid. The first method has already been described under aid to blind and aid for aged; that is, increasing the monthly payment to include the medical requirements. The difficulties of this method have already been discussed, but it does have the advantage of placing the greatest possible responsibility on the family for management of its affairs.

The cost of examinations either to establish eligibility or to determine medical needs may be charged to the administration fund. As in aid to blind the cost of services necessary to secure medical treatment may also be charged to this fund.

In ADC, it is also possible to pay the physician or hospital directly for medical services. This is done by setting up in the annual county budget an item specifically allocating a certain amount to medical care; this is subject to state reimbursement only, and amounts to approximately 50 per cent of the sum so disbursed. This provision is applicable to all members of the ADC family and covers dental as well as medical costs.

Where payment is being made directly to physicians and to hospitals, it is advisable for ADC to consult with the relief authorities in the county and attempt to work out fee schedules which are satisfactory to both agencies as well as to the medical profession.

#### GENERAL RELIEF

The poor relief laws provide that relief authorities shall give medical assistance to those in need of such care who can establish eligibility for poor relief.

##### Definition of Medical Care

Medical care includes medicines and services of a physician or surgeon (wherever rendered) or the emergency services of a dentist, furnished at public expense. The cost of hospitalization may not be paid, but certain services such as medicines, dressings, laboratory and X-ray examinations, when not included in the hospital per diem rate, may be charged to medical care and paid from poor relief funds at the rate of \$1.00 per day for patients determined by the agency to be medically indigent. Should a hospital prefer, it may keep a detailed record of the cost of medicines, bandages and other items of medical care rendered indigent cases, and present billing to the relief authority for each case rather than submit a bill for medical care at the rate of \$1.00 per day.

##### Dental Care

Under the relief statutes the services of a dentist are part of medical care. The most usual services are extractions and fillings, but other dental service may be granted in the discretion of the relief administrator. Dentures, for

example, are important to the health of an individual who has lost his natural teeth to the extent that there is a lack of sufficient incisal and masticating surfaces. The expenditure of relief funds to provide dentures in such cases is justified and legal.

##### Hospital Care

Poor relief authorities have no responsibility for providing hospital service. This is a legal responsibility of the township trustees or of the city in which the patient has a legal settlement. Hospitalization of non-residents is the responsibility of county commissioners.

##### Glasses

It is legal for a relief administrator to furnish glasses to a member of a relief family when, in the judgment of the relief administration, the person has a need for them. There may be need in the case of a child requiring glasses in his school work; in the case of an adult a pair of glasses may make him more employable; and the lack of proper glasses frequently contributes to the bad health of an individual.

##### Trusses, Braces, Crutches, Artificial Limbs and Other Medical Appliances

There are many instances where medical appliances are essential to the health of an individual. Also it often happens that the use of such appliances renders a person employable. It is proper for a relief administration to purchase such appliances from relief funds when they contribute to the health, comfort or employability of a client.

The Barden-LaFollette bill provides for the purchase of appliances (for persons who may become employable) through the Bureau of Vocational Rehabilitation Service of the Department of Education. For the visually handicapped the Division of Social Administration provides certain services in connection with physical restoration, training for employment and placement. County workers should be familiar with the possibilities of aid through these agencies.

##### Eligibility for Medical Care

Medical care is one form of "poor relief" as described in General Code Section 3391, and, in the language of the statute, "shall be furnished" by a local relief area "to all persons therein in need of such poor relief". The statute further provides that poor relief "shall be dispensed on a budgetary basis" and that it "shall be granted only after sworn application and proper home investigation to ascertain facts of need and available means of support". This establishes, therefore, that medical care is a basic responsibility of local relief authorities (and of the state through its matching provisions) when



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investigation discloses that resources are not otherwise available.

Cases which are active with the local agency and are in receipt of other forms of poor relief are, of course, also eligible for medical care. Persons whose resources have been found sufficient to meet the need for food, shelter, clothing and other necessities but are insufficient to meet medical needs would be eligible; this constitutes what is known as the "medically indigent only" group. Medical care from General Relief funds may also be made available, under certain circumstances, to persons who are clients of the Aid for Aged, Aid to Blind and Aid to Dependent Children programs; for example, the \$40.00 statutory limitation in AFA may make it impossible for that program to provide full medical care, or the financial inability of a county to meet the minimum needs of the AB or ADC program may make it impossible to meet all necessary care from those funds.

It is important for AB, ADC and AFA agencies to work out a plan with the General Relief agency to make available to the latter the necessary information through which the relief agency may determine readily the eligibility for medical care of applicants who are clients of the three agencies mentioned. Such information can be used by the relief agency when in its opinion the information is sufficiently recent and adequate to obviate the need for a home investigation of its own.

A relief agency extending medical care to clients of the AB, AFA, ADC and "medically indigent only" groups will require an application, and investigation and a budgetary determination in order to establish eligibility under the relief statutes. In determining eligibility for medical care, needs should be budgeted on the basis of 100 per cent of Standards of Assistance as shown in Section III of the Ohio Manual. This is true even in relief areas which are not making assistance payments on basis of 100 per cent of need. Medical care is necessary to protect the health and sometimes the life of the client or applicant and the request for it should be given prompt and preferred attention.

Eligibility for medical care must be established in the same way as for other types of assistance, including a sworn application, a home visit and an assistance plan to determine need on a budgetary basis.

Sections I, II and III of the Manual fully outline the procedures to determine eligibility for relief. They describe the intake interview, the application and reapplication, the home investigation and the budgetary process through which determination of eligibility is made.

#### Establishment of Fee Basis

It is the established custom of the medical profession to provide medical care on the basis

of a fee or charge assessed by the practitioner against his patient for the service rendered. Such fees vary, depending on the nature of the malady and the time required to effect a cure; and in private practice are often adjusted according to the ability of the patient to pay.

In setting up a program to provide medical care at public expense, it is necessary that the public officials who provide the funds reach an agreement with their local medical society or advisory committee, setting up a scale of fees for the various services which the relief agency expects to authorize in behalf of persons for whom it has responsibility. Such an arrangement guarantees comparable service to the client, equitable treatment to all physicians who serve the agency, and provides a basis for the submission of fees, their encumbrance and payment by the agency.

Each relief area is expected to submit to the State Department of Welfare, Division of Social Administration, three copies of the fee schedule agreed upon between the area and the physicians, dentists and hospital clinics with whom it has contracted to give medical care to its relief clients.

#### Medical Advisory Committee

The most satisfactory medium through which public officials of a city or county can determine an equitable schedule of fees for the treatment of indigent persons is the local Medical Society or an Advisory Committee selected by the Society to represent them. The Department of Public Welfare urges that such a committee be set up by each general relief agency where it does not already exist. When there are several public assistance agencies in a county it would be of great advantage to have the same Advisory Committee serve all of them, thus providing uniformity throughout the county.

Such a committee should include a representative of the dental profession; also, in areas where out-patient clinics are used for medical care there should be representation from hospitals. In that event the one committee would be available for consultation with public officials on rates for dental and medical fees, including out-patient clinical charges, and other matters of common interest in connection with the medical program.

#### Emergency Service

Physicians are sometimes confronted with a request for their services by persons who claim to be medically indigent, but whose claim can not be confirmed immediately. The physician may request the person to make application at the relief office for authorization and return later for treatment; however, if the applicant's need requires the physician to give immediate medical care, he may request the relief agency



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\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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to make an investigation after the service is rendered and advise him whether or not eligibility is established. An authorization should be issued promptly if the agency's investigation proves the person to be entitled to the service at public expense.

There will also be persons who apply for clinical care, claiming inability to pay the clinic fee, whose name will not be on the eligible list of the relief agency. Such persons may be referred to the relief agency to make application for general assistance (Medical Care), where his application can be taken and his eligibility determined. If it is the judgment of the hospital clinic that the applicant's need is so emergent that immediate service is advisable, it may request the relief agent to investigate eligibility after the service is rendered and report its finding. Should the investigation disclose eligibility, the hospital clinic would be advised that it could include the service to the applicant in its charges against the agency.

#### Medical Resources

There are two acceptable methods through which medical care can be provided by a local relief agency and reported to the state for matching. Both involve the establishment of fee schedules. Either one of them or a combination of the two may be used.

One method is that under which the public relief authority has made a plan with the local Medical Society or Advisory Committee to handle medical and dental care through private physicians and dentists, based on an agreed schedule of fees for that care. Sometimes the rates allowed by the State Industrial Commission are considered as a guide, and fees are fixed at those rates or some percentage of them. Under it the client has free choice of physicians among those who are willing to accept the fee schedule adopted.

The other acceptable method is one under which public authorities find it more feasible and economical to provide the bulk of medical care to indigents through the out-patient department of a hospital. This, of course, is not available except in the larger counties or cities where such out-patient clinical services exist. Such a plan is permissible under a fee agreement between the public relief authority and the hospital. The Advisory Committee would be of the utmost importance in working out a schedule of fees or charges which will be equitable to the public authority and at the same time cover, partially at least, the extra cost of drugs and facilities made necessary by attendance at the clinic of those persons in the community whose care must be paid from public funds. Medical care rendered by a clinic does not, of course, take care of the needs of clients who are bedfast, and must therefore be given medi-

cal service in their homes. This service may be rendered by private physicians, under an agreed schedule of fees, as outlined in the preceding paragraph.

#### Reporting

It is essential that an arrangement be set up by which medical services may be authorized by the relief agency, based on which the proper encumbrance may be made, verified by the agency and reported on RS-10 for matching by the state. In all except emergency cases an authorization form should be issued before the service is rendered, and transmitted to the physician, dentist or clinic by mail, telephone or through the hands of the client himself; the form should provide a place for certification by the physician, dentist or clinic as to the service given and a line for the signature of the client acknowledging the receipt of the service. This authorization should accompany the statements of physician, dentist or clinic against the relief agency for payment; statements should be rendered monthly, at the end of each month. It is obvious that prompt billing by the physician, dentist or clinic is of advantage, not only to those rendering the service but to the relief agency as well, so that payments may be promptly made. An agreement between the relief agency and the physicians or the clinic that statements would not be valid for payment unless submitted within a certain minimum period (e.g. sixty or ninety days) after the service is rendered should serve to accomplish this purpose.

In emergency cases authorization may be issued after the service is rendered, provided the patient is found eligible for medical care at public expense.

### Laboratory Can Be Paid for Blood Test Under Ohio E.M.I.C. Program

According to an announcement by the Ohio Department of Health, the Ohio E.M.I.C. program permits authorization of a fee of \$2.00 to approved clinical and pathological laboratories for making blood tests for syphilis of pregnant women eligible to participation in the E.M.I.C. program.

Under the Ohio Prenatal Blood Test Law, a blood specimen must be taken by the physician attending a pregnant woman and submitted to an approved laboratory.

Physicians attending pregnant women who are participants in the E.M.I.C. program should notify the Ohio Department of Health of the name of the approved laboratory to which the specimen is sent so the department can transmit proper forms to the laboratory and subsequently pay the laboratory for the work performed.



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# In Memoriam

**George A. Allison, M.D.,** Cleveland; Western Reserve University School of Medicine, 1895; aged 74; died Oct. 5. Dr. Allison began practice as a physician for the Baltimore & Ohio Railroad at Chicago Junction, now Willard. Later he located in Cleveland, where he was in general practice for 40 years. During World War II Dr. Allison was on the medical staff of the Fisher Aircraft Plant No. 1, Cleveland. Two daughters survive.

**James Thomas Combs, M.D.,** Cincinnati; Chicago Homeopathic Medical College, 1894; aged 77; died Sept. 30. A retired physician, Dr. Combs had resided in Cincinnati for many years. His widow, a daughter and son survive.

**Harry Hedgewick Drysdale, M.D.,** Cleveland; University of Wooster, Medical Department, 1901; aged 69; member of the Ohio State Medical Association; Fellow of the American Medical Association; member, American Psychiatric Association, and diplomate of the American Board of Psychiatry and Neurology, died Oct. 5. Dr. Drysdale completed his medical education after returning from the Spanish-American War, in which he served in Cuba in the Medical Corps. He was assistant superintendent of the Massillon State Hospital in 1901-02. After postgraduate study in Europe, Dr. Drysdale began the private practice of his specialty in Cleveland in 1911. During World War I he was a consulting member of Medical Advisory Board No. 7 there, and served as a medical examiner at the Armed Forces Induction Station in Cleveland throughout the war just ended. Dr. Drysdale had written many articles on diseases of the brain and the central nervous system. He was a member of the Union Club and a member of the staff of Charity Hospital. Surviving are his wife, a daughter and a sister.

**Herbert Collins Hanning, M.D.,** Dayton; College of Physicians and Surgeons, Baltimore, 1894; aged 77; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Hanning practiced in Dayton for 48 years. Surviving are his widow and a son, Dr. William H. Hanning, Dayton.

**Charles Stephen Hoover, M.D.,** Cleveland; Western Reserve University School of Medicine, Cleveland, 1901; aged 68; former member of the Ohio State Medical Association and the American Medical Association; died Oct. 7. Dr. Hoover retired from active practice six years ago. While a student at Western Reserve he enlisted in the Army and served for 10 months during the Spanish-American War, after which he re-

## DIED WHILE IN MILITARY SERVICE

**John A. Marsico, M.D.,** Elyria; Ohio State University College of Medicine, 1930; aged 41; member of the Ohio State Medical Association and the American Medical Association; died at the Osaka prison camp in Japan, according to a letter received by relatives recently from a now-liberated fellow prisoner. A captain in the Medical Corps, Dr. Marsico was captured by the Japanese in the fall of Corregidor in 1942. His widow, a sister and three brothers survive.

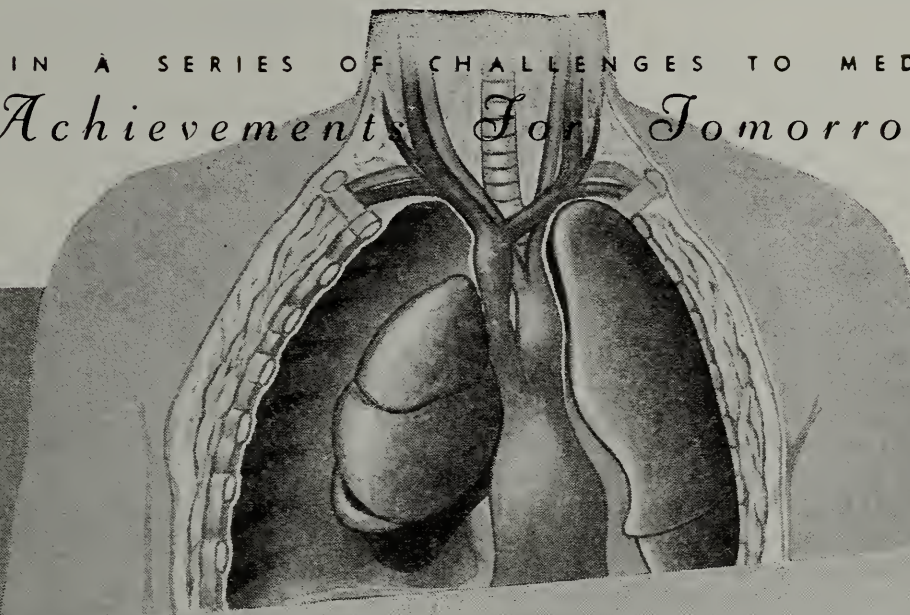
turned to Reserve to complete his medical studies. During World War I he again served in the Army, and was stationed at Camp Sherman, Chillicothe. For a short time after the Armistice Dr. Hoover practiced in Alliance, later returning to Cleveland. Active in social and fraternal organizations, Dr. Hoover was a member of the Masonic Order, the Sojourners, American Legion and the Congregational Church. Surviving are his widow, two daughters, a son and two sisters.

**Carl Ross Knoble, M.D.,** Sandusky; Starling Medical College, Columbus, 1905; aged 65; member of the Ohio State Medical Association and the American Medical Association; died Oct. 24. A former president of the Erie County Medical Society, Dr. Knoble practiced in Sandusky for nearly 40 years. He was actively interested in community affairs, having been a member of the local Board of Education for 26 years and president for 23 years, and a former president of the Plum Brook Country Club. Dr. Knoble was county coroner from 1908 to 1912. He was a member of the Presbyterian Church, the Masonic Order, Knights of Pythias, Elks, Eagles, Moose and the Maccabees. Surviving are his widow, a daughter, a son—Dr. Ross M. Knoble, Councilor for the Eleventh District of the Ohio State Medical Association, a sister and a brother.

**Howard Allison McKnight, M.D.,** Springfield; University of Pennsylvania School of Medicine, Philadelphia, 1910; aged 61; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; diplomate of the American Board of Surgery; died Oct. 7. A past-president of the Clark County Medical Society, Dr. McKnight had practiced in Springfield since 1924. During World War I he was a captain in the Medical Corps and chief of surgery of Base



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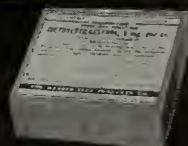
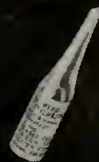
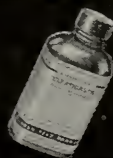
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Hospital 28 in France. Dr. McKnight's surgical training was received in Philadelphia under the late Dr. John B. Deaver, with whom he collaborated in the publication of "Surgical Anatomy". Dr. McKnight later occupied the chair of surgery at the Woman's College Hospital, Philadelphia. He was a member of the Men's Literary Club of Springfield and the American Legion. His widow and two sisters survive.

Clyde Earl Shinkle, M.D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 60; member of the Ohio State Medical Association; Fellow of the American Medical Association; member of the American Psychiatric Association; died Oct. 5. Dr. Shinkle practiced in Cincinnati for 35 years. He was a member of the staffs of Deaconess, Good Samaritan and Cincinnati General Hospitals. At one time he was assistant superintendent of the Longview State Hospital, and was on the teaching staff of the University of Cincinnati College of Medicine for 35 years. Dr. Shinkle was a member of the Alpha Kappa Kappa and Delta Kappa Epsilon fraternities. He is survived by his widow, two sons, his father, a brother and a sister.

John S. Suva, M.D., Cleveland; Creighton University School of Medicine, Omaha, 1911; aged 65; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 16. Dr. Suva practiced in Cleveland for 34 years. Surviving are his widow two daughters, two sons, two brothers and two sisters.

Gilbert Dillon Waite, M.D., Portsmouth; Rush Medical College, Chicago, 1918; aged 52; member of the Ohio State Medical Association and the American Medical Association; died Sept. 29. Dr. Waite went to Portsmouth in 1923, after having practiced in Elkins, W. Va., for two years. He was formerly chief of staff of Mercy Hospital. Active professionally until handicapped by poor health for the past year and a half, Dr. Waite was also well known throughout the state as an owner of riding horses. His entries had won ribbons in horse shows in Ohio, Kentucky and West Virginia. Dr. Waite was a member of Sigma Chi and the Elks Lodge. His widow, a daughter, a son, his mother and three sisters survive.

Frederick William Walz, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1878; aged 87; died Sept. 20. Retired from medical practice for some time, Dr. Walz was widely known in Cleveland because of his colorful civic and political career. He first held public office as a member of the Board of Education in 1885. From 1887 to 1891 he was county coroner and was a councilman during the Tom L. Johnson administration. In 1927 Dr. Walz was re-elected

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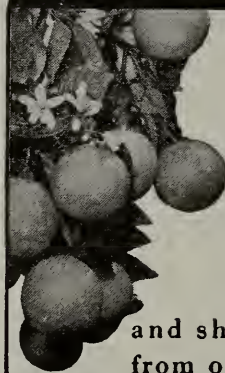
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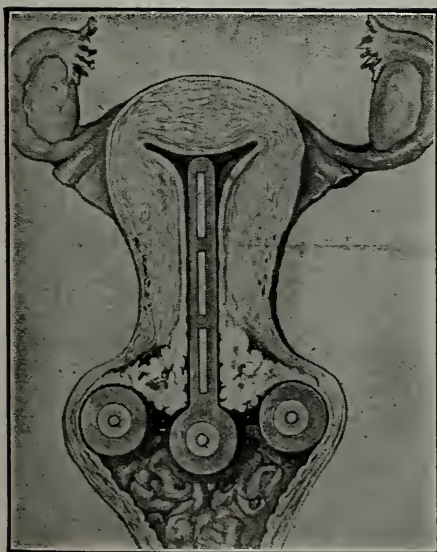
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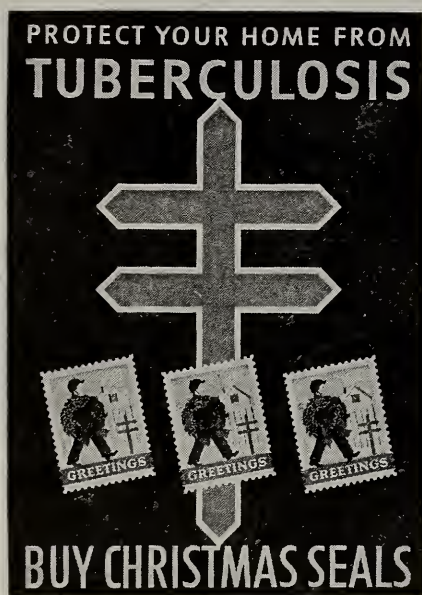


to the City Council, but resigned in 1931 in an unsuccessful attempt to become mayor. A vigorous opponent of political corruption, he was responsible for a probe which revealed big-scale graft in land sales for city playgrounds in the early '30s. Dr. Walz was an ardent travel enthusiast, and in 1938 made his fourth trip to Europe. His widow survives.

Earl Corson Wood, M.D., Columbus; Ohio State University College of Medicine, 1911; aged 64; died Oct. 14. A veteran of World War I, Dr. Wood practiced in Columbus until his retirement in 1939. He was a member of the American Legion. Surviving are his widow and two sisters.

### Christmas Seal Campaign To Open In Ohio on November 19

The 39th Annual Christmas Seal Campaign will begin in Ohio on November 19 and continue until Christmas. Its purpose is to raise funds to support the work of the National Tuberculosis Asso-



ciation, the Ohio Public Health Association and 88 county-wide health associations in their fight against tuberculosis.

Proceeds of the sale in Ohio last year were \$888,000. The funds are distributed as follows: Eighty per cent is retained by the local group for use in the community where the Seals are sold; 15 per cent is apportioned to the Ohio Public Health Association and five per cent goes to the National Tuberculosis Association.

Tiffin—Dr. Milton Smith, formerly on the staff of the Toledo State Hospital, is the new superintendent of Tiffin State Institute. He succeeds Dr. Jerry C. Price, who has become associated with the Bair Foundation Clinic and faculty of the Columbia University College of Physicians and Surgeons, New York.

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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M. D., CINCINNATI)

### ADAMS

Members of the Adams County Medical Society were guests of their colleagues in West Union at a meeting of the society, Oct. 24. Dr. W. L. Faul, Georgetown, spoke on "Some Tropical Diseases" at the morning session. The speaker in the afternoon was Dr. A. R. Quigley, Maysville, Ky., surgeon.—Hazel L. Sproull, M.D., secretary.

### BUTLER

Maj. A. J. Brogan of the Veterans Administration Facility, Dayton, spoke on the "Relationship of Civilian Physicians to Veterans' Affairs", at a meeting of the Butler County Medical Society, Sept. 27, at the Middletown Hospital.—News clipping.

### CLINTON

"The Care of the Returned Veteran", was the topic of a general discussion by members of the Clinton County Medical Society, at a meeting Oct. 2, at Wilmington.—R. W. DeCrow, M.D., secretary.

### HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during October:

Oct. 2—"Persistent Problems of Pneumonia", Dr. M. A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine.

Oct. 16—"The Present Status of Penicillin in the Therapy of Syphilis", Dr. George X. Schwemlein, co-medical director, Chicago Intensive Treatment Center, Chicago, Ill.—Bulletin.

### HIGHLAND

Dr. C. H. Skeen, Greenfield, spoke on "Non-Inhalation Anesthesia", at a meeting of the Highland County Medical Society, Oct. 3, at Hillsboro.—News clipping.

## Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

### MIAMI

Dr. Claude S. Wright of the Medical Research Department of the Ohio State University College of Medicine, spoke on "Utilization of Radioactive Isotopes in Medicine", at a meeting of the Miami County Medical Society, Oct. 5, at Stouder Hospital, Troy.—G. A. Woodhouse, M.D., secretary.

### MONTGOMERY

Dr. Ralph W. Eddy, Cincinnati gynecologist, was the guest speaker at a meeting of the Montgomery County Medical Society, Oct. 5, at Dayton.—Bulletin.

## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### PUTNAM

Dr. Guy E. Noble, St. Marys, spoke on "The Future of Medicine—Economic and Legislative", at a meeting of the Putnam County Medical Society, Oct. 2, at Witteborg's Cafe, Columbus Grove. The members present were very favorably impressed with Dr. Noble's presentation, in which he stressed the importance of more active participation by doctors in legislative matters.—J. R. Echelbarger, M.D., secretary.

## Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

### CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during October:

Oct. 10—Internal Medicine Section. "Arthritis and Rheumatism", Dr. Robert M. Stecher.

Oct. 12—Combined Meeting, Experimental Medicine Section of the Academy of Medicine and Cleveland Section of the Society for Experimental Biology and Medicine. "A Method of Calculating the Rate of Absorption of Exogenous Cre-

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atine", R. Domingues, M.D., and E. Pomerne, Ph.D.; "The Ability of p. Amino-hippuric Acid to Decrease the Rate of Renal Elimination", Lawrence Peters, Ph.D.; "Oral Administration of Penicillin", Alfred Free, Ph.D.; "The In Vitro Action of Penicillin on Staphylococci", H. C. Marsh, Ph.D., and R. F. Parker, M.D.

Oct. 19—Regular Academy Meeting. "Anesthesia in Cleveland—Past, Present and Future", Dr. Ralph M. Waters, professor of anesthesia, University of Wisconsin.—Bulletin.

### Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

#### PORTAGE

Dr. Raymond S. Rosedale, Canton, showed and explained an interesting motion picture film entitled "Plastic Surgery of the Nose", at a meeting of the Portage County Medical Society, Oct. 4, at Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

#### SUMMIT

"Treatment of Hypertension", was the subject discussed by Dr. Irvine H. Page, director of research, Cleveland Clinic, at a meeting of the Summit County Medical Society, Oct. 2, at the Nurses' Home, City Hospital, Akron.—Bulletin.

### Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

#### TUSCARAWAS

Comdr. Max Shaweker, M.C., U.S.N.R., home on leave after being in command of a naval hospital at Honolulu, was guest speaker at a meeting of the Tuscarawas County Medical Society, Sept. 13, at the City Hall, New Philadelphia.—News clipping.

### Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

#### MUSKINGUM

Dr. R. S. Martin spoke on "Mastoid", at a meeting of the Muskingum County Academy of Medicine, Oct. 3, at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secretary.

### Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

#### FRANKLIN

The Columbus Academy of Medicine presented the following programs during October:

Oct. 1—"The Principles and Objectives of the Association of American Physicians and Surgeons", Mr. Harry E. Northam, Executive Secretary, A.A.P.S.; Discussants: Dr. Jonathan Forman, Dr. C. C. Sherburne.

Oct. 15—"Problems in the Management of



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Arthritis", Dr. Richard H. Freyberg, director of medicine, The Hospital for Special Surgery, New York City; discussants, Dr. E. H. Wilson, Dr. B. K. Wiseman.—Bulletin.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### ASHLAND

Dr. Raymond S. Rosedale, Canton, showed a film "Plastic Surgery of the Nose", to ten members and two guests of the Ashland County Medical Society, Sept. 7, at the Ashland Country Club.

A motion to approve membership of Ashland County physicians in the Association of American Physicians and Surgeons was passed unanimously.—R. P. Bogniard, M.D., secretary.

### LORAIN

"The Differential Diagnosis of Anaemias", was the subject discussed by Dr. Bernhard Chomet, Elyria, at a dinner meeting of the Lorain County Medical Society, Oct. 9, at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secretary.

## WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)

Chairman, Publicity Committee

### BELMONT

Twelve members of the Belmont County Medical Society and the Woman's Auxiliary attended a 6 o'clock dinner Sept. 27, at the Belmont Hills Country Club to hear Dr. Verne A. Dodd, professor of surgery at Ohio State University. After Dr. Dodd's talk each group held a brief business session. Dr. C. W. Lose of Flushing was in charge of the medical society meeting, and Mrs. Lose presided at the auxiliary session. Plans were made to donate medical samples for the Polish War Relief at Akron. Members of the auxiliary present were: Mrs. Homer Ring, Mrs. J. B. Martin, Mrs. C. V. Porterfield, Mrs. W. E. Durr, Mrs. L. L. Liggett, Mrs. C. W. Lose, Mrs. Frank Harris, Mrs. Miles Garrison, Mrs. C. W. Kirkland, Mrs. L. D. Covert, Mrs. R. H. Wilson, Mrs. B. C. Diefenbach and a guest, Mrs. Verne Dodd of Columbus. The next regular meeting will be held at the Belmont Hills Country Club on Thursday, Oct. 25.

### BUTLER

The members of the Woman's Auxiliary to the Butler County Medical Society entertained their husbands on Wednesday evening, Sept. 26, at the home of Dr. and Mrs. H. J. Baker, 321 South D Street, Hamilton. A picnic dinner was enjoyed in the spacious gardens of the Baker home. Mrs. Fred Brosius, president, greeted the guests and presided at a brief business session. Several

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projects were discussed and action taken. One nurse in each graduating class of the Training Schools of Mercy Hospital, Hamilton, and Middletown Hospital will receive awards of \$25.00 each for high scholastic standing. *Hygeia* will be sent to all Junior and Senior High Schools in the county. Arrangements were made to collect samples of drugs from the doctors' offices to be shipped to Akron for the stricken peoples of Europe.

The program was in charge of Mrs. Ross Hill, chairman. Dr. Malcolm Cook, Hamilton, recently returned from two years' service in the European theater of war, gave an interesting talk on his experiences in evacuation hospitals. Rev. Reubin Pieters, Middletown, discussed the present international situation in Korea. Rev. Pieters' mother was a medical missionary in Korea, so he was well informed on this timely subject.

#### FRANKLIN

During the Summer months, chairmen of the various committees of the Woman's Auxiliary to the Columbus Academy of Medicine have been entertaining their committee members to make plans for the ensuing year. Mrs. George Cooperrider, president, was a guest at all meetings. Mrs. Albert Frost, program chairman, entertained at a luncheon, June 8, at the University Club.

Mrs. James H. Warren, membership chairman, entertained the committee with a tea at her residence on June 11. Mrs. Earl Ryan, project chairman, gave a luncheon for her group June 14 at the Faculty Club. Mrs. George Peters, telephone chairman, was hostess to her group at a luncheon at the Seneca Hotel. Mrs. Oscar Jepson, ways and means chairman, entertained at a dessert-luncheon at the Seneca Hotel for her committee. Mrs. Jerry Kerschner, social committee chairman, was hostess to her group at a luncheon at the Scioto Country Club on June 27. Mrs. William Miller, luncheon committee chairman, invited her group to a luncheon at her home on July 7. Mrs. Floyd Green, chairman of transportation, gave a luncheon at the Scioto Country Club for committee members July 11. Mrs. A. J. Shoemaker, chairman of the calendar committee, was hostess to her assistants at a luncheon at the University Club on July 12.

The opening meeting of the Woman's Auxiliary to the Columbus Academy of Medicine took place at the Jeffrey House on Monday, Sept. 17, at 12:30 o'clock. The theme of the party was "Meet Your Neighbors". Mrs. William Miller was chairman of the luncheon.

Officers for the ensuing year are: Mrs. George W. Cooperrider, president; Mrs. D. G. Sanor, vice-president; Mrs. Earl Baxter, president-elect; Mrs. John Briggs, past-president; Mrs. Frank Riebel, recording secretary; Mrs. Ivor Clark, cor-

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responding secretary; Mrs. Roy Krigbaum, treasurer.

#### HIGHLAND

The Woman's Auxiliary to the Highland County Medical Society held a meeting on October 3 at Hillsboro. The new officers for the year are: Mrs. W. M. Hoyt, president; Mrs. J. C. Bohl, president-elect; Mrs. J. M. Byers, vice-president; Mrs. C. H. Skeen, secretary-treasurer. Mrs. Skeen and Mrs. Byers reside in Greenfield.

#### LUCAS

Mrs. Frank B. McNierney, president of the Women's Auxiliary to the Toledo Academy of Medicine, has announced committee chairmen for the 1945-46 season.

They include Mrs. A. J. Kuehn, bulletin and handbook; Mrs. Clarence Hufford, finance; Mrs. John R. Davis, *Hygeia*; Mrs. Martin Diethelm, liaison; Mrs. A. W. Hemphill, library; Mrs. Henry D. Brown, legislation; Mrs. E. J. McCormick, membership; Mrs. Richard Hotz, program; Mrs. Rollin Kuebbeler, public relations; Mrs. Murray Goodrich, publicity; Mrs. James Miller, social; Mrs. Emil Mosbacher, telephone.

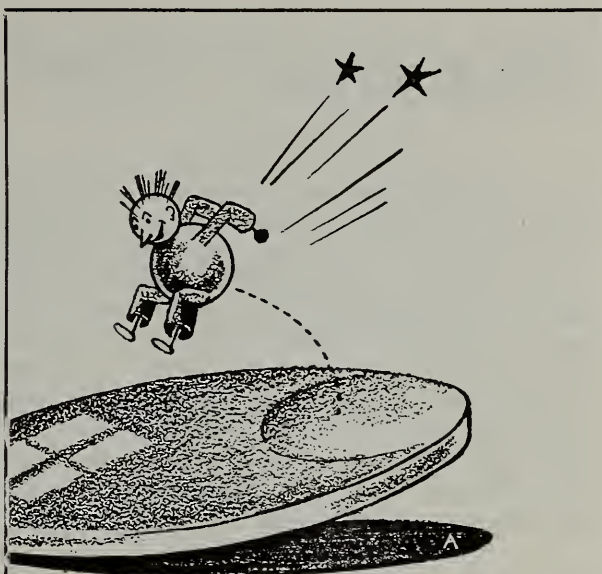
Mrs. John Stifel is vice-president for the coming season; Mrs. N. W. Kaiser, treasurer; Mrs. William Meffley, assistant treasurer; Mrs. W. A. Taylor, corresponding secretary; and Mrs. Wendell Green, recording secretary. Mrs. Norman Muhme is president-elect.

Wives of doctors in the service were honored at a tea given by the Auxiliary, Sept. 25, at the home of Mrs. Martin Diethelm. Members have been asked to collect samples of drugs received by their husbands and in the offices of other physicians, for Polish relief.

#### ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met at the Y.M.C.A., Chillicothe, on Sept. 6, with thirteen members present. Mrs. Loy Hoyt, president, conducted the business session. Standing committees were appointed for the year. Mrs. Walter Breth spoke on the health insurance program of the State Medical Association. Plans were made to order an incubator for the City Hospital.

On Oct. 5, a dinner meeting was enjoyed by the members at Allyn's dining room. Following dinner, the 14 members and three guests adjourned to the home of Mrs. Glen Nisley, West Second Street. Mrs. H. M. Crumley, vice-president, conducted the business session in the absence of Mrs. L. E. Hoyt. "Tuberculosis Control in Ross County" was discussed in a capable manner by Miss Lucy Thornton. Mrs. Walter Breth reported on the rummage sale, which was held for the benefit of the fund to purchase an incubator. A second rummage sale will be held in



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November. Mrs. R. E. Lightner, Kingston, was appointed to collect and send medical samples for the Polish War Relief.

### SCIOTO

Mrs. Tunis Nunemaker, Grandview Ave., Portsmouth, entertained 19 members of the Woman's Auxiliary to the Hempstead Academy of Medicine on Sept. 12. Mrs. William Singleton presided. Dr. Wells McCann, president of the Hempstead Academy of Medicine, gave an interesting talk on "The Medical Service Plan". Several projects were discussed for the ensuing year, and a decision made to furnish clothing for two small girls who have entered the class for crippled children at the U. S. Grant school. Refreshments were served following the business session.

### SUMMIT

A membership tea was given by the Woman's Auxiliary to the Summit County Medical Society, at the home of Mrs. J. G. Blower, Akron, on Sept. 27. Mrs. C. F. Wharton, president, greeted the members. Mrs. R. F. Thaw assisted on the hospitality committee. Mrs. Paul Davis, President-Elect of the Woman's Auxiliary to the Ohio State Medical Association, assisted at the tea table.

Special recognition was given the auxiliary recently, when the Blue Cross Hospitalization Association requested 5,000 pamphlets on "Do You Know", which pertains to the Wagner-Murray-Dingell Bill. Congressman Edmund Rowe was the featured speaker at a tea sponsored by the public relations committee recently. He told members and guests the implications of the bill and how it would affect their families. Mrs. Paul Davis was general chairman. Another splendid piece of work accomplished by the auxiliary, was the collection of 2,000 pounds of medical supplies from doctors' offices in Akron for the destitute peoples of Europe. It was such a success that the State Auxiliary adopted the plan, and numerous county auxiliaries are in the process of collecting sample medical supplies for the Polish War Relief in Akron.

### TUSCARAWAS

Members of the Woman's Auxiliary to the Tuscarawas County Medical Society and husbands enjoyed their annual picnic at Tuscara Park on July 29. Thirty members and guests were present. Mrs. J. W. Calhoon, Mrs. W. W. H. Curtiss and Mrs. C. J. Miller were in charge of arrangements.

The first regular meeting of the year was held September 13, at the home of Mrs. D. M. Cera-mella. The program was in charge of Mrs. Bell of Uhrichsville, who gave a review of the book "Pleasant Valley" by Bromfield. Following the business meeting refreshments were served.

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Out there in China as a liaison officer with the Chinese Combat Command, Capt. Charlets A. Bogue, Warren, comments: "How long we will be here—nobody knows—not even the Army."

\* \* \*

Capt. G. B. Ackerman, Columbus, with the medical detachment of the 51st M. P. Bn., on Okinawa, met up with one of his O.S.U. '42 classmates, Capt. Robert Burrell, Grandview Heights, a flight surgeon.

\* \* \*

During September and the first four days of October, the Army Medical Department separated 2,700 doctors from the service and by Christmas it is expected that 14,000 doctors will have been separated, Brig. General Raymond W. Bliss, Acting Surgeon General of the Army, stated recently before the House Military Affairs Committee. Through the months of July and August approximately 1,300 doctors were released.

General Bliss pointed out that in proportion to the Army's 45,000 doctors on VE-Day, there are now 43,000 in service, 2,000 of whom are recent graduates of medical school. He said a large number of doctors are needed to staff hospitals and separation centers, which are now at peak operation and these centers require a total of 2,000 doctors.

Stating the approximate total of patients still in Army hospitals to be 400,000, General Bliss concluded, "You can not treat patients without doctors . . . According to the laws of Congress you can not separate men without doctors . . . By Christmas we will have reduced the number of doctors by at least 14,000, which represents more than thirty per cent of the total corps. At the same time, we will continue to meet our first and foremost responsibility to give the American soldier the best medical care that any soldier in any Army has ever received."

\* \* \*

After two years out in the Pacific aboard the U.S.S. Rainier (A.E.S.), Lt. Comdr. Mel A. Davis, Painesville, is now stationed at the Separation Center, Shoemaker, Calif.

\* \* \*

Lt. (j.g.) Howard M. Schriver, convalescing at the U.S. Naval Hospital, Corona, Calif., contributes the following about fellow-Cincinnatians who visited him when he was hospitalized in Okinawa: Comdr. Orville Ramey is senior medical officer aboard a sea-plane tender in the Rhyukus, and went through the Battle of Okinawa. Lt. Comdr. Kenneth Martin was in Okinawa building a hospital. Lt. Comdr. Joseph

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Bolin was the radiologist at the hospital to and from which Lt. Schriver was evacuated.

\* \* \*

Capt. George W. Campbell, Columbus, who was taken prisoner at Bataan in 1942, has been released from a Japanese prison camp in Osaka, Japan. A graduate of the Western Reserve University School of Medicine in 1938, Dr. Campbell was a resident at the Elyria Hospital when he entered the service in 1941.

\* \* \*

Capt. Paul C. Grove, Newark, is assistant chief of medical service, 312th General Hospital, located at Manila.

\* \* \*

Recently transferred from the 5th Ferrying Group at Dallas, Maj. Trent W. Smith, Columbus, is base surgeon at Berry Field, Nashville, Tenn. Dr. Smith was stationed at an air field in Brazil for two years.

\* \* \*

Lt. Col. Clarence F. Murbach, Archbold, is commanding officer of the 231st General Hospital, at present based at Santa Maria, Philippine Islands, but expecting to move soon to Nagoya, Honshu Islands, Japan.

\* \* \*

Capt. Bernard Burgin, Cincinnati, who returned from the South Pacific in February, 1944, was recently transferred from the Army Medical Purchasing Office, New York, to the Professional Administrative Service, Physical Standards Division, Disposition and Retirement Branch, Office of the Surgeon General.

\* \* \*

Lt. John G. Feder, M.C., U.S.N., a native of Columbus, who was taken prisoner on Guam in December, 1941, cabled his wife recently that he was well and back on Guam. Dr. Feder, a graduate of Ohio State University College of Medicine in 1934, was commissioned in June, 1939, and went overseas in Oct., 1940.

\* \* \*

Capt. Isador Miller, Urbana, has high hopes of being home by Thanksgiving. He has been in Africa with the 56th Station Hospital for 30 months.

\* \* \*

At present a patient at Oak Knoll, U. S. Naval Hospital, Oakland, Calif., Lt. Comdr. Roy D. Hildebrand, Newcomerstown, participated in the invasions of Pelileu, Iwo Jima and Okinawa, as senior medical officer on the U.S.S. Sea Runner. He expects to be ordered to the Yosemite country soon to continue his convalescence.

\* \* \*

The Legion of Merit has been awarded to Col. Claude S. Beck, Cleveland, surgical consultant

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to the Fifth Service Command from November, 1942 to July, 1945. The citation said that Col. Beck "brought to the Army a wealth of background and training in surgery which he tirelessly imparted to the staffs of Army hospitals".

"By close and constant supervision over the personnel assigned to the surgical services of the command and over the procedure they carried out", the citation added, "he developed and maintained a high standard of treatment.

"He was alert and quick to put into use any worthwhile advances in surgical technique. By his energy, superior professional ability, broad vision and sound judgment, he made a material contribution to the war effort."

\* \* \*

Another Ohio medical officer homeward-bound from a Japanese prison camp is Capt. Julien M. Goodman, Cleveland, taken prisoner when the Philippines fell in 1942. Dr. Goodman graduated at Ohio State University College of Medicine in 1937. A reserve officer, he was called to active duty in Dec., 1940, and went to the Philippines in July, 1941.

\* \* \*

Recently promoted to his present rank, Lt. Comdr. Daniel S. Bunner, Columbus, has been out in the Pacific with Admiral Halsey's Third Fleet for over a year. Previous service included a year at a base hospital in North Africa and later with an amphibious unit during the invasion of Salerno.

\* \* \*

Add to the list of Ohio medical officers in and around Tokyo, Capt. O. J. Fatum, Van Wert, who is with the headquarters detachment of the 489th Port Battalion.

\* \* \*

Maj. Edward L. Montgomery, Circleville, who was with the 37th Division in the South Pacific for two and a half years, and is now on terminal leave, has accepted a fellowship in eye, ear, nose and throat at the Cleveland Clinic.

\* \* \*

Lt. Col. Ralph K. Ramsayer, Canton, is chief of the surgical service at Glennan General Hospital, Okmulgee, Okla. This 2000-bed hospital is designated for general surgery and orthopedics, with most of the patients battle casualties from both theaters.

\* \* \*

Since his return from the Southwest Pacific about 18 months ago, Lt. Col. Charles W. Voorhis, Cleveland, has been chief of surgery at the Regional Hospital, Fort Sheridan, Ill.

\* \* \*

Changes of locations within the United States: Capt. Robert Ringer, Cambridge, 1040 A.A.F.B.U., Santa Ana, Calif.; Maj. Glenn H. Walker, Woodville, Manhattan, Kans.; Capt. Ches-

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\* \* \*

Home on a 30-day leave after a tour of duty in the South Pacific, Comdr. Drew L. Davies, Columbus, has been assigned to the surgical staff of the U. S. Naval Hospital, Memphis, Tenn. Dr. Davies' "relief" as base medical officer in New Caledonia was a fellow-Ohioan, Comdr. Paul L. Yordy, Dayton.

\* \* \*

Redeployed directly from Italy to the Pacific, Lt. O. Warren Hattendorf, Cincinnati, is now stationed near Manila, P. I., with the medical detachment of the 337th Eng. C. Bn.

\* \* \*

Aboard the U.S.S. Fuller in the harbor at Yokohama, Comdr. S. W. Obenour, Zanesville, writes that he has orders to duty in (of all places) Columbus, Ohio. He will start home when his relief arrives, which he hopes will be soon.

\* \* \*

Top posts on the staff of the 254th General Hospital are held by three Ohioans: Col. J. O. Crist, Centerburg, commanding officer; Lt. Col.

Gilman D. Kirk, Columbus, chief of surgery and Maj. Robert C. Kirk, Columbus, chief of medicine. The 254th was in Southern France on V-J Day awaiting redeployment to the Pacific theater. It is now based at Camp Sibert, Ala.

\* \* \*

Capt. Ralph J. Starbuck, Salem, has been awarded the Air Medal for "meritorious and dangerous work" in the China theater.

### WIN PROMOTIONS

|                        |                   |                      |
|------------------------|-------------------|----------------------|
| Bayha, Carl H.         | Toledo.....       | Comdr., U.S.N.R.     |
| Bookwalter, Henry L.   | Columbiana.....   | Capt., U.S.A.        |
| Bunner, Daniel S.      | Columbus.....     | Lt. Comdr., U.S.N.R. |
| Chalker, Harry E.      | Girard.....       | Major, U.S.A.        |
| Daus, Homer J.         | Cleveland.....    | Major, U.S.A.        |
| Davis, Mel A.          | Painesville.....  | Lt. Comdr., U.S.N.R. |
| Goodman, Joe Irving    | Shaker Hts.....   | Major, U.S.A.        |
| Hartman, Joyce I.      | Cleveland.....    | Comdr., U.S.N.       |
| Herman, Wm. W.         | Cleveland.....    | Major, U.S.A.        |
| Hudson, J. Robert      | Cincinnati.....   | Capt., U.S.A.        |
| Jackson, Calvin G.     | Kenton.....       | Lt. Col., U.S.A.     |
| Johnson, David M.      | Columbus.....     | Comdr., U.S.N.       |
| Kalb, Nathan           | Cygnets.....      | Capt., U.S.A.        |
| Kerschgens, Lambert J. | Steubenville..... | Lt. Comdr., U.S.N.R. |
| McGreer, John T.       | Dayton.....       | Major, U.S.A.        |
| Ramsayer, Ralph K.     | Canton.....       | Lt. Comdr., U.S.A.   |
| Ransohoff, Joseph, II  | Cincinnati.....   | Capt., U.S.A.        |
| Rodabaugh, Franklin    | Toledo.....       | Major, U.S.A.        |
| Sharretts, Kenneth C.  | Cincinnati.....   | Major, U.S.A.        |
| Sringley, Robert S.    | Columbus.....     | Capt., U.S.A.        |
| Stickley, Louis P.     | Cincinnati.....   | Capt., U.S.A.        |
| Talbot, David R.       | Mansfield.....    | Comdr., U.S.N.       |
| Voorhis, Charles C.    | Cleveland.....    | Lt. Col., U.S.A.     |
| Wagner, Carl F.        | Cincinnati.....   | Major, U.S.A.        |
| Watson, Thomas W.      | Wayne.....        | Capt., U.S.A.        |
| Whitehouse, Stanley W. | Cincinnati.....   | Capt., U.S.A.        |
| Woliver, Edward        | Cincinnati.....   | Capt., U.S.A.        |
| Wright, Norman S.      | Springfield.....  | Capt., U.S.A.        |

### Appointments In Navy Open

The Bureau of Naval Personnel, Navy Department, Washington, has notified Offices of Navy Officer Procurement Service that they may accept and process for appointment to the United States Navy Reserve the application of any doctor of medicine between the ages of 21 and 50 and who is a graduate of an approved medical school, has visual acuity of at least 12/20 uncorrected and correctable to 20/20, is otherwise physically qualified, and has the clearance of the Procurement and Assignment Service.

It was stated that no procurement campaign would be initiated but that physicians who might desire to join the Medical Corps, U.S.N.R., may apply under these conditions to any Navy Officer Procurement Office. Offices serving the area in which Ohio is located are at Cincinnati and Detroit.

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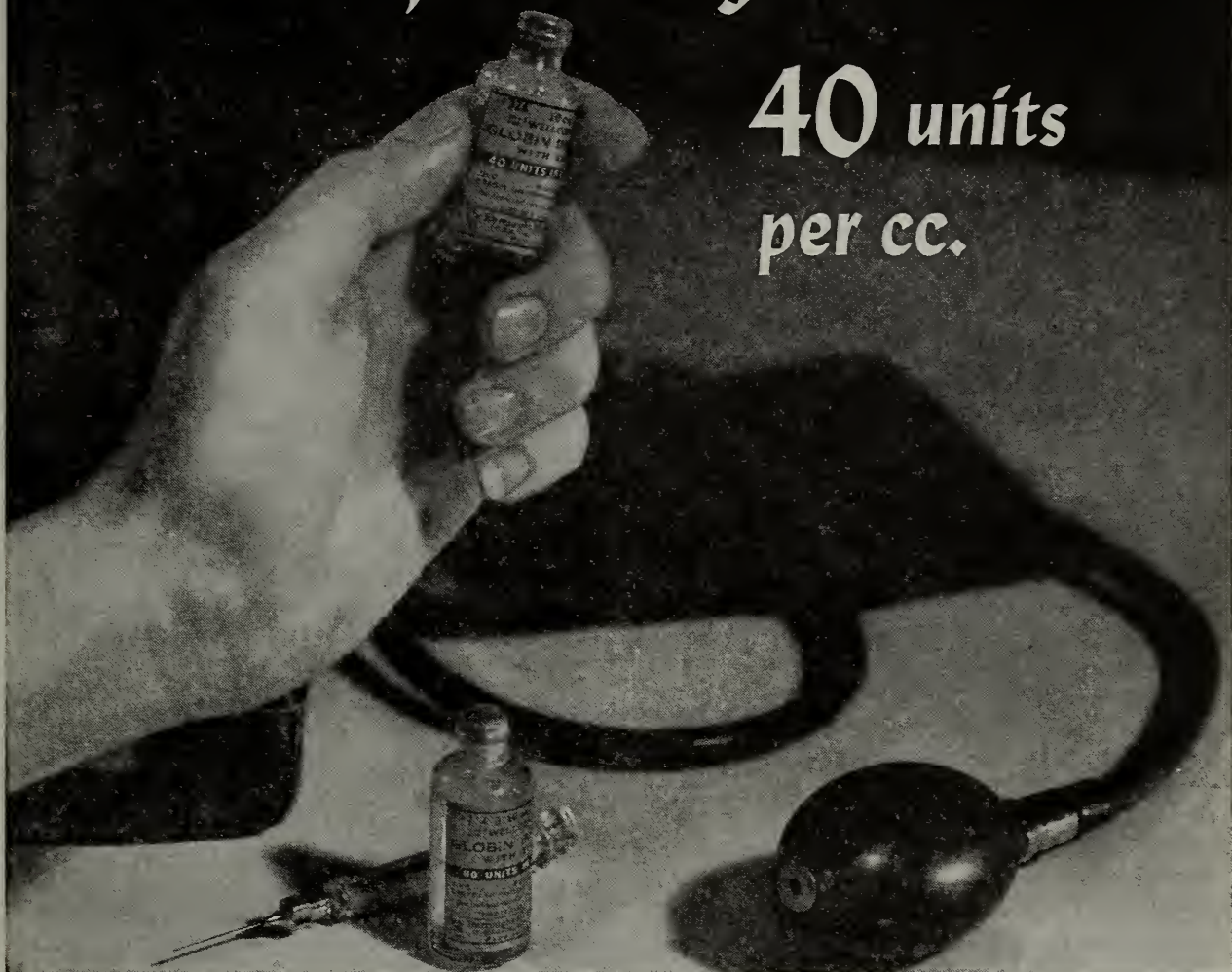
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**Psychiatry in Modern Warfare**, by Edward A. Strecker, M.D., and Kenneth E. Appel, M.D., (\$1.50. *The Macmillan Company, New York City*) presents a study of what we should have learned in the last war and post war days that can be used now.

**I Married Them**, by Janet Van Duyn, (\$2.50. *Howell, Soskin & Company, New York City*) is the story of the girl who thought that she had married a young physician but she found she had married his whole family—three generations of physicians. You will enjoy this tale.

**How to Get and Keep Good Health**, by Stella Regina Dolan, editor, (\$2.00. *Bernard Ackerman, Inc., New York City*) is the wide little volume in which 23 experts tell how to maintain mental and physical fitness.

**Man Against Pain**, *The Epic of Anesthesia*, by Howard Riley Raper, D.D.S., (\$3.50. *Prentice-Hall, Inc., New York City*) is a dentist of Albuquerque who was born and reared in Chillicothe, Ohio. Here we have the results of 30 years of research and study as a hobby by this man who comes from a family of Ohio writers. This book belongs in the library of every student of anesthesia and every student of medical and dental history.

**New Directions in Psychology: Toward Individual Happiness and Social Progress**, by Samuel Lowy, M.D., (\$3.00. *Emerson Books, Inc., New York City*) attempts to put to work more fully in the service of man, our now considerable knowledge of the science of mentality and behavior. It is a book about doing things to enrich our lives. It is, therefore, a valuable book with a general appeal.

**Health Instruction Yearbook 1945**, edited and compiled by Oliver E. Byrd, (\$3.00. *Stanford University Press, California*) should be a welcome visitor to the desk of every physician as a most effective source book for the whole field of health. The editor, an authoritative person in the field of health education, has analyzed 1421 references and of this number has selected 316 for inclusion in this present volume setting forth current thought, experience, and research in this field.

**A Cereal Source Book**, edited by Agnes G. Reasors, Home Economics Director of The Cereal Institute (*Apply Cereal Institute, Inc., 135 S. LaSalle St., Chicago 3*), has been published as a service to those preparing editorial copy on food and nutritional material. It gives a good background of information of interest to all who study nutritional problems.

**Biological Symposia, Vol. XI, Ageing and Degenerative Diseases**, edited by Robert A. Moore, M.D., (\$3.00. *The Jaques Cattell Press, Lancaster, Pa.*) presents a symposium held at Washington University. The major theme is arteriosclerosis. The volume is a worthwhile contribution to geriatrics.

**The Hebrew Medical Journal**, under the editorship of Moses Einhorn, M.D., (*931 Park Ave., New York City*) celebrates the beginning of the eighteenth year with an interesting special volume.



# The Ohio State Medical Journal

*Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.*

Vol. 41

December, 1945

No. 12

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *News Editor*

## Psittacosis as a Cause of Atypical Pneumonia. Penicillin Therapy.\*

ROBERT F. PARKER, M.D.

IN much of the literature of atypical pneumonia, the implied assumption is that it is "a disease," having as its cause an elusive virus. While it is possible, if indeed not probable, that a given outbreak may have as its cause a single pathogen, all the evidence at hand points to a multiplicity of agents as the "cause" of atypical pneumonia. Under these circumstances, to call it by a name implying that it is an entity rather than a syndrome may handicap advance by giving the impression that the cause is known. Further, while many cases are due to infection with a virus and might therefore be called virus pneumonia, to call the group "viroid" pneumonia implying that the causal agent is not a virus but something resembling it adds unnecessary confusion. The purpose of this communication is to record two cases of pneumonia, the viral cause for which was established, and to call attention to the fact that in spite of much control work, psittacosis is still an important disease.

Case 1. E.P. A white woman of 61 years. Two weeks before admission, the patient was taken with fever and malaise. In the two days before admission, she had developed a non-productive cough. At the time of admission to the hospital she appeared acutely ill but suffered from no obvious respiratory distress. Physical examination revealed dullness to percussion at the base of the left lung with crepitant rales audible in this area. The heart was slightly larger than normal but no murmurs were heard. Blood pressure was 130/80. An X-ray examination of the chest at this time was indeterminate. With one brief remission the temperature remained at about 40.5° C. for the first 7 days of hospitalization, the pulse ranging from 100 to 110.

### *The Author*

● Dr. Parker, Cleveland, Ohio, is a graduate of Washington University School of Medicine, St. Louis, 1929; member, American Society for Clinical Investigation and the Society of American Bacteriologists; associate physician, Lakeside Hospital; and associate professor of medicine, Western Reserve University School of Medicine.

The total white blood cells numbered 10,300 per cu. mm. on admission and mild anemia was present. The urine contained a few white cells and + to ++ albumin. Sputum culture revealed a mixed bacterial flora.

Sodium sulfadiazine was given empirically for 3 days with no apparent effect. Beginning on the 5th hospital day, penicillin was given (120,000 units per day); the fever fell to 37.5° on the 7th day and fluctuated between 37.5° and 38.5° for several days thereafter. Clinical improvement was evident at about this same time, which was approximately the 21st day of the disease. An X-ray examination of the chest on the 5th hospital day (19th day of disease) revealed diffuse haziness which was interpreted as being due either to pneumonia or passive congestion. It had disappeared by the 14th hospital day.

It was learned that some two weeks before the onset of this patient's illness she had been given, as a Christmas present, two parakeets, one of which was sick. These were brought in for examination and the virus of psittacosis was recovered from them. Serum taken on the 21st day of illness fixed complement in a dilution of 1/128 with psittacosis antigen, and a sample taken in convalescence gave a titer of 1/256. These tests were kindly made by Dr. K. F. Meyer.

Case 2. A.S. This 52-year old housewife was brought to the hospital acutely ill. She had been

\*From the Department of Medicine, Western Reserve University, and Lakeside Hospital, Cleveland, Ohio. Submitted August 1, 1945.

taken sick four days before with shaking chills, fever, severe headache and pain in the back. The day before admission she developed a severe cough and became irrational. On admission her temperature was 41.3° C., pulse 107, and blood pressure 150/80. She was quite lethargic and mildly disoriented. Dullness was discovered at the base of the left lung and crepitant rales were heard in this area. An X-ray examination of the lung was indeterminate. The white blood count on admission was 5,550. The highest count during the first two weeks in the hospital was 8,200. An X-ray examination of the chest on the 6th hospital day revealed pneumonia infiltration about the hilus and possibly in the left base. Sputum culture revealed a mixed flora of bacteria.

During the first week in the hospital the patient continued acutely ill; the temperature ranged between 39.5° to 40.5°; the pulse from 95 to 105. On the 8th hospital day (13th day of illness) penicillin was given in daily dosage of 160,000 units. The temperature began to fall by lysis on the 10th hospital day (15th day of illness) and reached normal by the next day. A large decubitus ulcer developed which gradually healed under penicillin, tyrothricin and supportive therapy.

It was learned that the patient kept a flock of pigeons. Some of these were examined. Their serum did not fix complement with the specific antigen, nor could virus be recovered from them. The patient's serum, however, fixed complement specifically; a sample taken on the 12th day of illness was positive in dilutions of 1/16 and on the 23rd day in a dilution of 1/64.

#### DISCUSSION

In both of these cases the diagnosis of broncho-pneumonia was established clinically; in neither were bacteria found of the sort which might be expected to lead to a primary bacterial infection of the lung and no basis for secondary infection was evident; by exclusion a viral cause might have been postulated. In Case 1 the fact that the illness occurred at the Christmas season and that the patient had received a present of a sick parakeet pointed strongly toward psittacosis as the cause. In Case 2 only industrious questioning of the patient's family by the House Staff revealed the fact that a flock of pigeons were kept on the patient's premises. That her infection was acquired from them might be questioned since no evidence of infection of the flock with psittacosis could be secured. That pigeons constitute a serious public health hazard is supported by a number of studies.

Penicillin was used in each case and in each a beneficial effect may be claimed. The demonstration, however, suffers from the defect of all other reported cases<sup>1,2</sup>; the drug was exhibited late in the disease when spontaneous recovery was to be expected. Psittacosis in man is a self limited disease, the duration given variously as 2 to 4 weeks. It is, therefore, very difficult to say in any small group of cases that treatment begun at the end of two weeks of illness and followed by recovery is actually responsible for the favor-

able outcome. That penicillin should be effective in psittacosis appears to be suggested by some of the experimental work with the disease. Heilman and Hérrell<sup>3,4</sup> obtained favorable results in mice, using a small inoculum and treating early in the infection when they gave 1,000 units per day in divided doses. The treatment seemed less effective when its beginning was delayed beyond a few hours from the time of inoculation of the mice. However, 1,000 units per day in a 20 gram mouse corresponds to 3.5 million units per day in a 150 pound man. In work with chick embryos, we<sup>5</sup> found benefit to result from treatment, but only when concentration of penicillin of 3 to 10 units per cc. were used. While penicillin should not necessarily be withheld in psittacosis, careful examination of the data at hand suggests that not much is to be expected from doses customarily used.

#### SUMMARY

Two cases of atypical pneumonia are presented in which the virus of psittacosis was shown to be the causal agent. It is pointed out that "atypical pneumonia" is more likely a group of diseases than a single entity. Penicillin was used and recovery followed. The defect in the demonstration that penicillin was responsible for cure is pointed out.

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#### Please Accept Our Apologies!

*The Journal* desires to apologize to its readers for having published erroneous biographical and professional data regarding one of the authors of the article, "Coach Leg", which appeared on page 1012 of the November issue. Because of a similarity of names, professional data, and military rank, credit for being a co-author of the article was given to Dr. A. C. Ormond, Zanesville, instead of to Dr. Alexander P. Ormond, Akron. Our apologies to both of them, also.

Dr. Alexander P. Ormond, Akron, co-author with Dr. Paul S. Ross of the interesting article referred to, is a graduate of the University of Pennsylvania School of Medicine in 1925; diplomate of the American Board of Internal Medicine; member of the American College of Physicians and is at present a Major in the Medical Corps, A.U.S., on active duty at Robins Field, Ga.



# Dihydroergotamine (D.H.E. 45) in the Treatment of Migraine: Preliminary Clinical Observations

MAURICE D. FRIEDMAN, M.D., and DANIEL A. FRIEDMAN, A.B.

ERGOTAMINE tartrate has been established as a very useful preparation for the treatment of the migraine attack. Some authors claim that when given early in adequate dosages, ergotamine will abort 80 per cent of true migraine attacks. Ergotamine tartrate, however, possesses certain side effects which are undesirable and which contribute nothing to its therapeutic efficiency. About a year ago, our attention was called to an improved ergotamine (dihydroergotamine, D.H.E. 45) which abolished certain of the undesirable effects and maintained the curative qualities of the original preparation. It was decided to try this preparation in a group of private patients in whom a clear-cut diagnosis of the migraine syndrome could be made.

The characteristic symptom complex of recurring intense headache, usually unilateral, frequently preceded by visual aura, and often associated with general malaise, nausea and vomiting is sufficiently dramatic to offer no great diagnostic problem. If, in addition to these symptoms, there is a history of familial incidence, the diagnosis is even more certain. It should be noted that patients with true migraine experience almost complete freedom from symptoms between attacks. Careful physical and neurological examination must, of course, be made in every case, and the findings of these examinations should reveal no structural or systemic cause for the headache.

Following these criteria, a group of 20 cases was selected and treated with D.H.E. 45\*. One cc. of the material containing 1.0 mg. of dihydroergotamine was given intramuscularly to each of these patients during their attacks. Many of these patients were referred to us because of the failure of the usual forms of treatment to provide them with any relief. Routine histamine sensitization tests using the Atkinson technique were performed on all cases in this series. Where a strong positive reaction occurred, the value of histamine desensitization treatment was pointed out to the patient. But in those people with infrequent attacks who obtained relief from a single injection of D.H.E. 45, desensitization treatment was often refused. Eighteen of the 20 patients treated obtained dramatic relief within 25 minutes following the injection. The pa-

## *The Authors*

● Maurice D. Friedman, Cleveland, Ohio, is a graduate of the University of Michigan Medical School, Ann Arbor, 1924; diplomate, American Board of Psychiatry and Neurology; member, Cleveland Neurological Society; senior attending neurologist, Mt. Sinai Hospital; consulting neuropsychiatrist, Polyclinic Hospital, Cleveland, and St. Elizabeth Hospital, Youngstown; associate director, Neuropsychiatric Institute, Cleveland.

● Daniel A. Friedman, Cleveland, Ohio, is a graduate of Harvard University, 1944, and a student in Western Reserve University School of Medicine.

tients with very severe migraine left the office unrelieved after the injection and did not return for follow-up study.

A second series of 20 cases, with severe recurring functional headache which did not fulfill the criteria of the migraine syndrome, were treated in a similar manner with dihydroergotamine merely to complete the clinical experiment. No therapeutic effect was noted in these cases.

There were no manifestations of toxicity in any of the cases treated.

## REPORT OF CASES

The following abstracts illustrate the type of case treated and the therapeutic result obtained:

Case 1. Very severe migraine status; excellent relief following the use of D. H. E. 45.

Mrs. R. R., aged 22, white, was referred because of severe recurrent headaches, unilateral in character, associated with nausea and vomiting, which were unrelieved by usual anodyne medication. Her headaches began with a stabbing pain in the right temple which continued to increase in severity until it became "almost unbearable". Associated with the headache was a marked drop in mood and a severe hyperirritability. Neurological and physical examinations were negative and all laboratory studies, except the histamine sensitization test, were non-contributory. There were no important personal factors which were considered contributory to her illness. In view of the negative findings, a tentative diagnosis of migraine syndrome was made. One cc. of D.H.E. 45 (1.0 mg.) was injected intramuscularly. The patient left the office considerably relieved one-half hour later. We were advised by the patient's father that for the first time in a month, the patient "seemed like herself again".

Submitted July 19, 1945.

\*This material was kindly supplied to us by the Sandoz Chemical Works, Inc., New York 14, New York.



One week later, the patient called our office frantically asking if she might come in for another injection as her "headache was beginning again". Another injection of 1 cc. of D.H.E. 45 (1.0 mg.) was given with prompt relief from all symptoms within one-half hour following the injection. A third recurrence, one week later, was treated with similar therapeutic effect after injection. There has been no recurrence of symptoms for the past two months.

**Case 2.** Very severe recurrent headache of the migraine type; complete relief from attack by D.H.E. 45; successful treatment with histamine desensitization.

Mr. R. G., aged 31, white, factory employee, was referred because of severe recurrent headache of the left side accompanied by nausea and syncope. This patient stated further that as the headache began to subside, he noticed a mucoserous discharge from the left nostril. This latter symptom suggested possible allergic factors for which a careful search was made in the dietary habits of the patient. It was because of this that histamine skin testing was done. The patient was found to be strongly sensitive to histamine. Physical and neurological examinations were negative. Other laboratory examinations, including pneumo-encephalogram, were non-contributory. The patient's mother suffered from headaches of a similar type. Although histamine desensitization treatment was decided upon, it was deemed worthwhile to abort his present attack with D.H.E. 45. One cc. (1.0 mg.) of the material was injected intramuscularly with prompt symptomatic relief. Treatment was then carried on with intravenous histamine desensitization. The patient has been free from symptoms for the past six months.

**Case 3.** Severe migraine status; failure to respond to D.H.E. 45; histamine sensitive; did not return for follow-up study.

Mr. D. K., aged 38, white, was referred because of severe unilateral pain in the right temporal region associated with lacrimation of the right eye. His attacks had been recurring at irregular intervals over the past 12 years, becoming more frequent and intense during the past two months. The history suggested the syndrome of erythromelalgia of the head as described by Horton. Several members of the patient's family were afflicted with headaches of a similar type. Physical, neurological, and laboratory findings were negative with the exception of a very strongly positive histamine skin sensitivity. The patient received very little benefit from one cc. of D.H.E. 45 (1.0 mg.) given intramuscularly. He was advised to enter the hospital for further study and histamine desensitization. This advice was disregarded and follow-up study can not be further reported. This is one of the two cases in which a one cc. intramuscular injection of D.H.E. 45 (1.0 mg.) was ineffective in relieving the vasospastic syndrome. However, it is possible that a larger dose in such a severe case might have been effective.

**Case 4.** Functional headache; no relief following the use of D.H.E. 45; improved by psychotherapy.

Mrs. A. R., aged 45, white, with two children, was referred with a complaint of migraine. In obtaining the history, it was noted that the patient had had headache "as long as I can remember. It is present almost all the time and any excitement or fatigue makes it worse." On occasion the headache is associated with nausea and vomiting. This headache was not unilateral

but was diffuse and had none of the classical features of migraine. In addition to the headache, the patient complained of various other somatic pains, also of facile fatigability, and showed evidence of a considerable drop in mood. Neurological, physical, and laboratory studies were non-contributory. There were personal factors of sufficient importance to provoke emotional tension. Therefore, the illness was diagnosed as a psycho-neurotic reaction with neurasthenic and hypochondriacal components. This is one of the cases in which D.H.E. 45 was used to further our clinical experiment. No therapeutic effect was expected and none was obtained.

#### SUMMARY AND CONCLUSIONS

1. An improved ergotamine preparation has been tried clinically with excellent effect in the treatment of the true migraine syndrome. It is at least as specific or more so than ergotamine tartrate and has the advantage of being devoid of the undesirable side effects.

2. Histamine sensitive cases of migraine with frequent attacks can be benefited further by histamine desensitization treatment.

3. In favorable cases, dramatic relief from the migraine symptoms can be obtained within 20 to 30 minutes following intramuscular administration of 1.0 mg. of D.H.E. 45.

4. D.H.E. 45 has no specific value in the treatment of undifferentiated functional headaches.

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#### X-Ray in Tuberculosis

Benefits of Roentgen's ray are striking in the fight against tuberculosis. Before X-ray the physician had to depend upon sound and touch to find tuberculosis. By the use of X-ray, however, tuberculosis can be discovered in its early stages; treatment can be begun when it will do the most good. Today new and improved X-ray equipment makes low-cost X-ray examination of the chest possible for everyone. Such mass X-raying of apparently healthy people gives new hope for the complete elimination of tuberculosis.

To the zeal and creative genius of a scientist will go much of the credit for this promised conquest of disease. For, although X-ray equipment has undergone notable development, the principle of the X-ray itself remains the same as when laid down by Wilhelm Conrad Roentgen in his laboratory on November 8, 1895.



# The Allergenic Effect of Silica and Its Relation to Dyspnea in Silicosis

WILLIAM J. HABEEB, M.D.

FOR many years the dyspnea and wheezing respiration exhibited by miners was called "miners asthma" by physicians and laymen alike. However, after the advent of radiographic examination of the lungs, it became known that "miners asthma" was due to silicosis or silico-tuberculosis. At the present time, the generally accepted explanation for the respiratory disability in silicosis is that it is entirely the result of pulmonary fibrosis and emphysema. Another explanation<sup>1</sup> which completely rejects fibrosis and emphysema and has not gained wide acceptance is that the dyspnea of silicosis is due entirely to capillary occlusion in extensive areas of the lung with compensatory capillary dilatation in other areas.

While there is a general relationship in cases of silicosis between the amount of nodular fibrosis as shown by the X-ray film and the degree of respiratory disability, this relationship is by no means precise and many cases show considerable disparity. The disparity suggests that factors in addition to fibrosis and emphysema enter into the problem.

What are the other factors? A categorical answer to the question can not be given because the respiratory disability in silicosis is most likely due to several anatomic and physiologic changes which include silicotic infiltration (nodular or not), emphysema, capillary occlusion, capillary dilatation and bronchospasm; not to any single one of these factors alone, as claimed by Cole, et al.<sup>1</sup> The known pulmonary changes consequent to and attending silicosis have been repeatedly discussed in the medical literature. However, a new factor in silicotic dyspnea has recently come to light, namely bronchospasm, which is the chief concern of this report.

## EVIDENCE OF BRONCHOSPASM

In the body, silica is not an inert substance as formerly believed but is appreciably soluble and has a chemical and physico-chemical action. Some silica on contact with body fluids is partially converted into toxic, highly active colloidal silica<sup>2</sup> while some is converted into soluble form which has no specific, known effect. Gardner and Dworski<sup>3</sup> first noted that colloidal silica produces symptoms in guinea pigs suggestive of bronchospasm. This observation led to further investigation by Gardner's colleagues<sup>4</sup> who have

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presented convincing experimental evidence that colloidal silica causes bronchospasm. They isolated guinea pigs' lungs, distended them with perfusion fluid, then produced multiple bilateral bronchopleural fistulae by needle pricks and measured the rate of flow of various fluids from the fistulae through the tracheobronchial tree.

Among the materials whose rate of flow were tested were colloidal silica, soluble silica, aqueous solution of particulate silica, aluminum hydroxide, gold sol. and epinephrine. Of the materials tested only epinephrine, which causes bronchodilatation and an increase in the rate of flow, and colloidal silica, which showed a decrease in the rate of flow, had any effect. The rate of flow is a test of the patency of the tracheobronchial tree and, in the case of colloidal silica which caused a decrease in the rate of flow, they concluded that the decrease was the result of bronchoconstriction.

**Epinephrine Test**—The relief afforded silicotics by the administration of epinephrine is clinical evidence that bronchospasm is a major factor and that it plays an important role in the dyspnea of silicosis. This observation<sup>5</sup> was recorded by me in a paper submitted for publication several months ago and, also, was cited as an unpublished observation by Wright<sup>6</sup> in another paper<sup>4</sup> shortly thereafter.

**Histamine Test**—It has been shown<sup>5</sup> that blood eosinophilia occurs in over 50 per cent of patients with silicosis and that the eosinophilia is proportional to the extent of the fibrosis and emphysema. Clinical evidence was presented and experimental evidence was cited which seemed to support the conclusion that the eosinophilia in silicosis was due to emphysema and its invariable consequents, alveolar distension and expiratory delay. In the light of the work of Filley, et al., this conclusion is invalid and must be revised.

Eosinophilia with few exceptions is considered

to be part of a generalized allergic response. The essential cause is not definitely known but one theory is that the eosinophilia is the result of histamine mobilization while a converse theory holds that eosinophilia is the result of an increased need for histamine which is thought to be carried by the eosinophils. For the purposes of this discussion it does not matter which theory is correct, but it is well known that histamine causes bronchospasm in patients with asthma but has no such effect in normal subjects. In order to test its action in silicosis it was administered to 20 patients with uncomplicated second and third stage silicosis. All but three patients developed variable degrees of dyspnea, wheezing and respiratory distress as if they had performed exercise. Therefore, histamine has the same bronchospastic effect in silicosis as in asthma. The histamine test strongly suggests that the bronchial musculature in many silicotics is sensitive to and reacts to histamine exactly as in asthmatics and is further evidence that the bronchospasm in silicosis has an allergic basis.

#### ANALOGY BETWEEN THE EFFECT OF ALLERGENS AND SILICA DUST

In drawing a parallel<sup>5</sup> between asthma and silicosis it has been pointed out that several anatomic and physiologic changes are common to both conditions. These changes include emphysema, bronchospasm, eosinophilia, decrease in vital capacity, increase in residual air, high alveolar carbon dioxide tension, low alveolar oxygen tension, decrease in tidal air and several others. It is well known that the eosinophilia and bronchospasm in asthma are the result of an allergic reaction due to a multiplicity of allergic agents. Can then, the eosinophilia and bronchospasm in silicosis be the result of an allergic reaction due to colloidal silica? Can colloidal silica be classified as an allergen? Its ability to produce bronchospasm and eosinophilia would seem to warrant its designation as an allergenic agent.

Allergens were all formerly thought to be protein only in nature but this view is no longer held. Many allergens are now known which are non-protein. Why, then, can not silica dust be an allergen? It produces bronchospasm and eosinophilia though not invariably or to the degree produced by pollens, danders and the like. Further, a high percentage of silicotics have bronchospasm and more than 50 per cent of miners with silicosis have eosinophilia, but it is safe to say that nothing approaching 50 per cent of the population, practically all of whom are exposed to such allergenic agents as dust, dander and pollen, have a sensitivity to these agents or develop eosinophilia and bronchospasm.

If silica dust possesses allergenic properties,

it is safe to carry the analogy between asthma and silicosis even further. Not only are many anatomic and physiologic features common to both, as previously stated, but even the etiologic agents have a common quality, which is, the ability to produce eosinophilia and bronchospasm. The analogy is not far fetched. It is believed that the observation of Filley, et al., that colloidal silica produces bronchoconstriction plus the observation that eosinophilia occurs in silicosis and is proportional to the stage of silicosis, warrant the conclusion that silica has allergenic properties which are partially responsible for the respiratory disability in silicosis.

#### SUMMARY AND CONCLUSION

Recent experiments and observations have shown: (1) Colloidal silica produces bronchospasm in isolated guinea pigs' lungs, (2) epinephrine clinically relieves dyspnea and bronchospasm in silicotics, (3) histamine clinically causes dyspnea and wheezing in silicotics due to bronchospasm, and (4) a high percentage of silicotics have a blood eosinophilia which is proportional to the extent of their disease. In view of this evidence it seems safe to conclude that silica dust has allergenic properties.

The relative role played by such factors as fibrosis, emphysema, bronchospasm, capillary obstruction and dilatation in silicotic dyspnea has been discussed. It is believed that no single factor accounts for the respiratory disability but that all play a variable part.

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If tuberculosis is to be eradicated, it is essential that the rate at which infectious cases develop in the population be maintained permanently below the rate at which infectious cases are isolated and prevented from spreading the disease. Furthermore, the greater the disparity in the two rates, the more quickly will this eradication be achieved. These fundamental principles, pointed out by Frost, must be constantly borne in mind in the planning and execution of every tuberculosis control program in every community, if success is to be attained.—Herman E. Hilleboe, M.D. & Arthur W. Newitt, M.D., *Journal-Lancet*, April, 1945.



# Preliminary Report: Low-Calcium Treatment of Poliomyelitis

BERT C. WILEY, M.D.

FROM the experience gained and observations made with the 162 poliomyelitis patients handled by the Department of Physical Medicine of the Miami Valley Hospital during the epidemic of the Summer and Fall of 1944 at Dayton, Ohio, and from a study of most of the recent medical literature upon this disease, it was concluded that the calcium content of the water-supplies used by the patients was a specific factor in their contracting the disease.

The apparently new theory that the poliomyelitis virus requires ionized calcium for its propagation, and an apparently original treatment based upon that theory are supported in part by the following observations and reports:

1. Investigation of the precipitation, water-supplies and the incidence of poliomyelitis throughout the country revealed a statistically significant relationship between dry seasons and the incidence, and a slight but also definite correlation between the total hardness of the water and the incidence. As yet incomplete studies indicate that there will be an even closer direct relationship between the calcium-content of the water-supplies and the incidence.<sup>1</sup>

2. Ingested calcium is mainly absorbed in the upper portion of the small intestine<sup>2</sup> (relatively the same location in which the highest concentration of the poliomyelitis virus is found post mortem<sup>3</sup>).

3. While the serum contains 9 to 11.5 mg. of calcium only 5 to 6.5 mg. are diffusible, and 4.75 to 6.25 mg. are ionized.<sup>2</sup> The cerebro-spinal fluid contains approximately the same concentration of ionized calcium as the serum.<sup>2</sup> The spinal fluid is a second favorable location for the growth of the virus.<sup>3</sup>

4. Of the pregnant women who contract poliomyelitis, 17.1 per cent are in their first trimester; 34.2 per cent are in their second trimester; and 48.6 per cent are in their last trimester of pregnancy.<sup>4</sup> This relative incidence of poliomyelitis corresponds rather closely with the development of the fetal skeleton, and therefore, the transportation of calcium from the mother's intestine or skeleton to the fetus; and it might be assumed that there is a correspondingly higher concentration of the ionized calcium during these latter periods.

5. It has been a rather general observation that it is the healthy and active children who

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usually get poliomyelitis. Closer observation and questioning also reveals that most of the patients like to drink milk (supply of calcium), drink hard water (greater quantities consumed during hot, dry weather—supplying more calcium,—and magnesium, which may be a catalyst), and have a very good suntan (through its production of vitamin D increasing the absorption of calcium).

6. Calcium is more soluble in an acid medium, and its absorption and union with other chemicals is hindered by the presence of phosphorous<sup>5</sup>. Therefore, sodium acid phosphate has been used with meals in an effort to prevent the absorption (or utilization by the virus) of what little calcium is ingested.

7. A possible reason why the poliomyelitis virus can not be grown in vitro is that all calcium carbonate (and probably all calcium) is automatically removed from solution in the media by its precipitation by the heat used to sterilize the culture media.

8. A possible reason why most virus diseases cause a low wbc is that the high concentration of calcium in bone favors the growth of enough virus in the marrow to retard the production of white blood count.

9. In a large proportion of polio patients, the disease is initiated by a gastro-intestinal disturbance, usually with emesis—signifying the presence of a disturbing condition in the stomach or upper portion of the small intestine.

10. A possible reason why the polio virus seems to grow best in the upper portions of the small intestine, is that the ingested calcium is kept soluble in the acid media of the stomach, but upon reaching the alkaline media of the duodenum tends to unite with the virus (protein) which has an affinity for it, as the solubility of the calcium is decreased.

11. The hospital course and results in earlier

cases at the Miami Valley Hospital this year and (in effect) "control" cases which were not placed upon this regime did not fare any better than similar cases handled last year, and had relatively more severe courses, and poorer end results than those patients treated with the low-calcium-sodium acid phosphate regime.

#### RATIONALE OF TREATMENT

If it is true that most polio virus enters the body through the gastro-intestinal tract, grows most readily in the upper part of the small intestine, and requires ionized calcium as an essential nutrient, elimination of practically all calcium intake by a low-calcium diet and soft water will reduce the extrinsic nutrient, while oral administration of sodium acid phosphate will tend to keep the intestinal contents acid so that their normal calcium fraction will remain soluble and can, therefore, readily unite with the phosphorous and thus become unavailable to the poliomyelitis virus. No attempt is made to change the calcium content of the blood-stream, since several patients showed increased serum calcium while on the low-calcium diet. The treatment is directed entirely to the reduction of the ionized calcium content of that portion of the gastro-intestinal tract in which the poliomyelitis virus usually reaches its highest concentration.

If the virus colonies are prevented from obtaining an essential nutrient element before they have grown to such numbers as to produce irreversible damage to muscle function, the progress of the disease will be stopped, inflammatory damage will gradually resolve, and the residual effects of the disease will be lessened. The low-calcium attack upon poliomyelitis is, theoretically, totally ineffective in changing the course of the disease or its end results to the extent that irreversible changes involving muscle function have already occurred at the time the treatment is started.

Since no harm is now foreseen from employing the low-calcium, sodium acid phosphate treatment over a period of three or four weeks, it may be expected that if this regime were instituted as soon as the possibility of poliomyelitis is suspected, the disease as previously clinically defined would never develop. On the other hand it would be nutritionally dangerous to advocate the elimination of all high-calcium foods from the diet indefinitely. At present, the low-calcium, sodium acid phosphate regime is arbitrarily continued for one week after the temperature drops to normal.

#### TREATMENT OUTLINE

1. Sodium acid phosphate gr. 5 to 15 (according to size) is given orally stat and t.i.d. at meal time.
2. A low-calcium, high carbohydrate, low vit-

amin D diet is offered in the most normal consistency which the patient can swallow.

3. Soft water is urged.

4. In addition, our previous routine is continued as follows:

a. Prostigmine bromide 15 mg. given orally t.i.d. as long as abnormal muscle irritability continues.

b. Phenobarbital and aspirin as indicated.

c. Soapsuds enema q.o.d., PRN.

d. Catherize PRN.

e. Hinged bed-board under a firm mattress, and foot-board.

f. Hot-wet packs to only spastic muscles: on 15 min., off 15 min-30 min. for eight sets of packs per day.

g. Physiotherapy of joint-motion, muscle training and activity as rapidly as the patient's condition permits.

#### CASE REPORTS

Eleven consecutive cases upon which this treatment has been tried beginning on July 16, 1945, are reported as evidence that the rate and degree of recovery under the low-calcium, sodium acid phosphate regime, has so far, surpassed previous results. It will still require several years to safely appraise the merits in end-results of this treatment of poliomyelitis.

Case 1. A.T. a 7 year old girl had an onset of nausea, emesis and stiff neck five days before treatment was begun, by which time she had a temperature of 102.2°, had moderate involvement of her posterior neck, back, right hamstrings and calf, and left shoulder, with rapidly progressing pharyngeal paresis. The spinal fluid showed 160 cells, mostly lymphocytes. Two days later her temperature had persistently dropped to below 100°(R) and a morning muscle examination showed complete relaxation of her neck, left shoulder and right calf. She was able to eat soft foods easily and to drink fairly well in a sitting position. Four days after the beginning of treatment she could talk and drink easily and had only a slight residual tightness in her low back; and four days later was able to stand and walk and perform exercises normally.

Case 2. B.R. a 3½ year old boy had an onset of weakness and then pain in his left hip followed by a fall one day before admission, when he revealed extreme spasm of his low back, and left iliopectas, and moderate spasm in his left calf. Treatment was started about 5 P. M. of the day of admission. By noon of the next day he was able to completely relax and straighten his left leg without pain; the following day he could keep his knees extended while sitting, and on the next day walked with only slight weakness of the left iliopectas, and could get his head to within eight inches of his extended knees while sitting. Four days later he was found "chining" himself on the outside of his crib.

Case 3. D.M. a 7 year old boy had pain in his left hip and limped one evening. By the next evening the pain and weakness had increased and he had fallen once. The next morning when



treatment was begun, he showed spasm or weakness of his entire left hip, thigh, and calf. By that evening all pain and spasm had disappeared, but he was still clumsy in moving his left leg through weakness. By the following afternoon all muscle involvement had cleared except a slight tightness of his low back, but he was able to kiss either knee while standing upon the opposite leg without losing his balance.

Case 4. L.F. a 33 year old nurse had an onset of gastro-intestinal disturbances, and progressive severe headache six days before our treatment. Two days after her onset, she had pain in thighs and calves, followed by involvement of her back, neck, and finally both arms and hands. Admission temperature was 103°. She had been given sulfonamides and penicillin by her LMD upon the provisional diagnosis of epidemic meningitis which was upheld by her admission rigidity, but laboratory and muscle findings indicated poliomyelitis and the prior treatment was stopped. In addition to our routine treatment which was started about 6 P. M. she was given oxygen PRN for her headache. By the following morning her temperature was persistently below 99.8°. That afternoon her headache had completely disappeared without oxygen, she had a good appetite, a normal BM, and could sit up. The next day she was able to walk unassisted, but had a slight right peroneal flip and sartorius incoordination, which had practically cleared by three days later.

Case 5. R.L. a 4 year old boy developed pain in his right hip and calf one evening, slept fitfully all night, and limped with a right foot-drop the following morning. He was admitted that evening with spasm or weakness of his back and entire right leg, with a temperature of 100.6° at the time treatment was begun. Two days later his temperature was normal and his right foot and calf had cleared. Two more days later his only remaining involvement was a slightly tight low back, but he could kiss either knee while standing unsupported upon the opposite leg.

Case 6. D.C. a 21 year old nurse had low back pain 5 days before admission. This was followed by increasing bilateral leg pains and headache with rapid onset of practically complete paralysis of both legs from the waist down, for two days during which time she was given sulfonamides and penicillin at another hospital. By admission she also had complete urinary retention and a severe headache, when treatment was begun in the morning. By the next morning her temperature was normal and there was an obvious beginning return of muscle function in both legs. By the next day, all muscles were functioning, she voided normally for the first time, and expelled a copious BM with an enema (previous enemas had been re-siphoned with little results). When lying on her sides, she could fully move both legs. Two days later she could sit alone with her feet over the side of the bed. Two days later she stood alone with assistance but with good hip and knee stability. Two days later she walked with assistance about six feet with good trunk and leg stability. Two days later she started being walked about four feet from her bed to sit up in a chair for most meals. Two days later she began to have normal daily BM's without enemas.

Case 7. L.B. a 9 year old boy had an onset 4 days before admission which progressed from anorexia, malaise, sore throat, progressive stiff neck and back, with muscle pain in both shoulders, to practically complete paralysis of both arms by 4 P. M. of his admission day. At that

time he showed only traces of muscle function in his right arm, slightly more strength in his left arm, marked weakness of both entire legs, barely perceptible rib-cage respiratory movement, a very tight neck and back, and a temperature of 104.6°. Treatment except the sodium acid phosphate was begun immediately and by the next day his temperature was down to 101.8°, there was fair rib respiratory movement at 30 R, there was no muscle pain or spasm except for a moderately tight low back, and he could flex his neck and right elbow slightly. The following day sodium acid phosphate was started and his temperature persistently stayed below 99° within 16 hours. Four days after admission there were normal rib respirations and a generalized return of muscle power. Three days later he could balance both forearms vertically on his elbows, and had a fair grip in both hands.

Case 8. E.M. a 14 year old boy began with headache, stiff neck, fever, anorexia, sore throat and diarrhea five days before admission, at which time he showed a temperature of 102.6° sluggish deep tendon reflexes, moderate weakness of his entire right leg, and 330 cells in his spinal fluid. Beginning treatment included oxygen. The next morning his headache had disappeared, and by that night his temperature was normal, his right leg strength had returned to normal, and there was only slight posterior neck and back tightness which loosened completely with only occasional muscle stretching by six days later.

Case 9. W.Q. a 20 year old boy had an onset three days before admission with headache, malaise, and a temperature of 102°. He was placed upon sulfonamides with resulting emesis. Two days later there was marked cutaneous irritability, exaggerated deep tendon reflexes, stiff neck, painful back, and almost total mental confusion at the time of his admission when there were 76 cells in his spinal fluid. For the first day and a half sulfadiazine was given, and although he took fluids very well, he was unable to eat and continued to be very irrational. A muscle tremor developed and his temperature continued erratically between 101° and 102°. On the evening of his second hospital day the low-calcium and sodium acid phosphate regime was started and he displayed some appetite. He was then given 10 per cent glucose intravenously and was less restless during the night. The next day he was somewhat rational, ate full meals well, had a normal temperature, and stated that he felt better. The following day he cleaned his own teeth, continued to eat and drink well, was quite rational and expelled an enema without difficulty. The following day he was entirely rational, smiled readily and showed only a generalized weakness, with moderate posterior neck and back stiffness.

Case 10. M.W. a 16 year old girl had an onset five days before admission and progressed through general malaise, stiff neck, and anorexia to dysarthria and a temperature of 102° on the second day when she was taken to another hospital for intrathecal penicillin. At that time she had 110 cells 70 per cent of which were lymphocytes in her spinal fluid. The next day nystagmus appeared, the pharyngeal paralysis increased, there was a marked accumulation of mucus in her throat, and there were beginning evidences of respiratory embarrassment. She was then brought to our hospital at 9:45 P. M. when she had diplopia, generalized incoordination, irregular shallow respirations, great difficulty in swallowing, and urinary retention. She was given 15 gr. of sodium acid phosphate at 10:15 P. M. and voided with only slight exertion at 1:00 A. M.



She was then given 2 gr. of sodium phenobarbital and slept the balance of the night. The following morning, her temperature was normal, and she was able to rinse her mouth with water, expectorate mucus, and then drink fairly well when lying on her side. That day she ate all meals fairly well, and slept all of the following night under 2 gr. of sodium phenobarbital. The second morning after admission she had no pharyngeal mucus accumulations and was able to drink fluids without trouble when in the supine position, could talk fairly plainly, and a muscle examination showed only moderate tightness of her posterior neck and back, marked weakness of her left sternocleidomastoid, and generalized weakness with occasional marked weakness of the right iliopsoas. Three days later she was able to sit up with her feet over the side of the bed and feed herself.

**Case 11.** F.G. a 9 year old boy began with a sore throat. Four days later both arms and legs were weak and numb, and marked anorexia began. Two days later he was allowed to go to a movie, and fell unconscious in his seat at 10 P.M. He apparently had not revived consciousness, been able to sit, make a purposeful movement, void, or speak until his admission the following day at about 1 P. M. when he showed great cutaneous and mental irritability. He was given 10 gr. of sodium acid phosphate at 2:45 P. M. and by 5 P. M. he was still confused but able to satisfactorily cooperate in a muscle examination, to sit up, and to speak a few words. There was generalized incoordination, moderate tightness of the posterior neck and back, and bladder distention up to the level of the umbilicus. At 7 P. M. he voided 500 cc. and later expelled an enema well, and then slept most of the night. The following morning his temperature was normal, he was entirely rational, had a normal BM, could eat and drink without trouble, was fully articulate in speech, and a complete muscle examination showed only normal hamstring tightness and moderate generalized weakness. The following day he could walk on his bed, but could not kiss his knees while standing upon the opposite leg without holding onto support.

#### SUMMARY

An apparently new and original method of treating poliomyelitis and polioencephalitis is outlined, consisting principally of a very low-calcium intake and the administration of sodium acid phosphate. There is a listing of supporting observations and reports, and case-studies upon eleven consecutive patients treated by this method at the Miami Valley Hospital. Although these cases displayed unusually rapid and complete recovery, they are far too few to constitute an adequate trial of the method, and several years must still elapse before their end-results can be definitely ascertained.

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## KEEPING UP WITH MEDICINE

**CAREFUL** history will usually allow the physician to determine whether or not a clinical problem is on an allergic basis.

\* \* \*

**FUNDAMENTAL** social need today is in the development of the public opinion that alcoholism is a disease and that the alcoholic is a sick man deserving of the sympathy and care which rightfully belong to one who is ill.

\* \* \*

**THERE** are fifty-five million users of alcohol in the United States of whom some two million use beverages to the extent that renders them liable to alcoholism. Another half million have become alcoholics to such a degree that they have impaired their physical and mental health.

\* \* \*

**A**T 6½ feet the magnification of the image of the heart on the X-ray film is reduced to less than 5 per cent.

\* \* \*

**A** PART from the distortion there are numerous other pitfalls in the interpretation of X-rays of the heart. Among these are the extra-pericardial fat pad, skeletal deformities, and pulmonary disease.

\* \* \*

**I**N allergic families, abdominal pain is often due to a food allergy. Skin tests here do not help in very many instances.

\* \* \*

**P**ATIENTS with dermatitis of the face should always be asked about their recent part in dramatics for facial makeup may have the sensitizing ingredient.

\* \* \*

**W**E do not live by bread alone. Sometimes we live by catch words; witness the way psychosomatic medicine has caught on. It is easy enough to say Mind-Body in Greek and call it English and something new. The word denotes that man is made of two parts, but is used now to denote that he is one. Strange business this language!

\* \* \*

**N**OW comes an Englishman to challenge our liquid restriction in edema. He gives several liters a day and no salt supposed to dilute the plasma proteins. So water is now used to expel water!

\* \* \*

**I**NCREASING the family's consumption of Vitamin-A containing foods is good for old and young. It tends to have a stabilizing effect on growth and to postpone aging and increase the length of life. New data suggests that two or three times the recommended amounts is more favorable than less amounts.—J.F.



# A Modification of The Syncope Syndrome in Coramine Premedicated Blood Donors and The Relationship of This Syndrome to Circulatory Shock\*

ROBERT D. BARNARD, M.D.

**C**OLLECTION of over 10 million pints of blood from more than three million voluntary blood donors has redirected attention to the age old phenomenon of "fainting" or "swooning" which occurs under the emotional stress of what physicians would regard as a trivial medical episode. Interest in the syncope syndrome transcends the desire to eliminate an unpleasant (and not always minor) complication of blood donation. Studies on syncope subjects who have come under observation as a result of war time conditions (blood donors; military recruits undergoing routine physical examination or inoculations; trainees in specialized programs such as those conducted by the air and armored forces; those working under conditions of high temperature and humidity), have indicated that the syncope syndrome is an ubiquitous medical phenomenon and that its engendering mechanism might be closely related to that which underlies such apparently diverse manifestations as heat stroke on the one hand and surgical shock on the other.

Many excellent studies, both statistical and experimental, have appeared on the subject of blood donor syncope but aside from the recognition of a strong "psychogenic" element, there is little unanimity of opinion as to its ultimate physiologic mechanism. Hyperventilation alkalosis,<sup>1</sup> vasovagal reflex due to diminished blood volume,<sup>2</sup> hyperactive carotid sinus,<sup>3</sup> and the elaboration of humoral agencies (other than the diminished plasma CO<sub>2</sub> content implied in the hyperventilation theory) have all had their advocates. In 1943, Milhorat and his associates<sup>4</sup> demonstrated the appearance of a cholinergic substance similar but apparently not identical with acetylcholine in the blood of subjects under emotional stress and Barnard<sup>5</sup> concluded that the complete syncope syndrome could be explained as the reaction of certain physically predisposed individuals to an excess of systemic acetylcholine liberated from the hypothalamic area as a result of psychogenic factors. It was later admitted that other factors must be operating in addition to acetylcholine intoxication in order to explain the phenomena observed.<sup>6</sup> However, within the past year additional evidence has accumulated to indicate an im-

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portant role for some cholinergic hormone in the genesis of shock-like states.<sup>7</sup>

Like the theories as to its genesis, the forms of treatment proposed for donor syncope have been diverse. Those who favor a vaso-vagal reflex origin have administered atropine. The author's results with atropine both in donor syncope and in cholinergic shock in rats produced by carbimid (cyanamide) intoxication were disappointing. Arenstam<sup>1</sup> institutes rebreathing to induce a rise in CO<sub>2</sub> tension of the blood (on the basis that donor syncope might be a form of hyperventilation tetany). Certain observers use adrenalin even though this is given during the adrenergic phase of the syndrome; a procedure to which Freeman<sup>9</sup> has attached theoretic objections.

After the advocacy by Gunther<sup>10</sup> of rather large doses of coramine (nikethamide) in surgical shock, its use was instituted as a treatment of syncope since we considered surgical shock to be an aggravated projection of the latter. Gunther administered the drug intravenously; in blood donor center practice restriction to oral use is usual. For the treatment of donor syncope, intravenous coramine has been very effective;<sup>11</sup> on oral administration the results, at least as judged by the circulatory response of the subject, have not been clear cut. From a clinical standpoint, however, it has been considered to be satisfactory by those donor centers which use it routinely, for even though the circulatory response to oral coramine is not more rapid than in untreated syncope subjects, there is the impression that there is earlier restoration of color and activity.

When it is considered that most syncope subjects recover completely without any treatment whatsoever, this discordance in clinical appraisal can be understood. Likewise on the basis of the present study, it can be appreciated that, as reported by one investigator, coramine medi-

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Submitted Sept. 10, 1945.

cation may actually aggravate blood donor reaction in certain patients. While a similar aggravation, by coramine, has been reported by Weiss<sup>12</sup> in experimental nitrite syncope, it is believed, for reasons that will be developed later, that conclusions derived from animals on the genesis and treatment of shock-like conditions should be applied to humans only with extreme circumspection because shock-like states in the human, with their conspicuous psychogenic component, are qualitatively different from that which has been produced experimentally in any other animal.

There is little occasion for the prophylaxis of blood donor syncope in current practice. By an evaluation of the physical stigmata of vagotonic individuals already described,<sup>6</sup> it is possible for experienced donor center personnel to exclude such as donors. Judicious barbiturate premedication will probably suffice in any other situation where syncope is anticipated though the barbiturates are certainly contraindicated in certain phases of industrial or military medical practice because of their effect on the reaction time. The point is academic for in most instances the creation of a situation contemplative of a syncope reaction is unjustifiable. Before the last conclusion had been drawn, however, a study had been conducted on the effect of oral coramine premedication on blood donor syncope. The results of this study are reported and discussed in connection with the coincidental findings which are considered to transcend in importance the fact that coramine is unsuitable as an agent for the prophylaxis of syncope.

#### EXPERIMENTAL

The subjects for the study were drawn from two sources.

(1) Donor applicants to the Columbus ARC blood donor center who gave a history of "fainting" on slight provocation, e.g., the "sight of blood" and who exhibited the physical stigmata which characterize the syncope reactor. As mentioned previously,<sup>6</sup> it is possible to select those who will react to donation, beforehand, with surprising accuracy.

(2) The blood donor volunteers from the Federal Industrial Institution at Chillicothe, Ill., formed another study group. The individual donors in this second group had been adequately controlled inasmuch as data had been collected and analyzed on approximately 500 donations by this group previous to the coramine premedication study. The group was made up of males in the age bracket in which we could anticipate a rather high reaction rate (though in the controls this proved not to be the case). Predisposing factors in the development of blood donor syncope<sup>2</sup> (viz., fasting, fatigue, malnutrition) had been eliminated by the institution authorities

who had supervised activity of the individuals composing the group for the 48 hours preceding donation.

Between July 7 and Nov. 6, 1943, 529 donors from the Federal Institution had each given a pint of blood on one or more occasions. There were 255 single-time and 239 redonors in the group; the number of syncope reactions was 23 which constituted a rate of 3.8 per cent. Even waiving the fact that all the individuals were within the age bracket in which syncope reactors are found, the percentage is regarded as significantly low as compared to that of non-institutionalized donors (7 per cent).<sup>2,6,13</sup>

On Nov. 6, 1943, 161 donors were given 5 c.c. of 25 per cent coramine, orally, 10 minutes before bleeding. Four reactions were observed, all of the syncope type; apparently this dosage of coramine has no prophylactic value at least insofar as can be evaluated from this small series. On Nov. 7, 10 c.c. of oral coramine solution was administered 10 minutes beforehand to 145 donors. Again there were four reactors but in all of them, of a type not hitherto observed. Instead of syncope, the reactors evinced confusion, in one instance to the point of disorientation which lasted for several minutes. Two of the patients required hospitalization overnight (an infrequent advent in ordinary syncope).

The phenomena observed in ordinary blood donor syncope and those exhibited by the coraminized donors is tabulated insofar as concerns those points which lead us to believe that there is a quantitative difference between two types of reaction. The remarkable feature of the reaction in coramine premedicated subjects (which was borne out by those reacting after coramine among the selected subjects in Group I) was its development in spite of what appeared to be, on the basis of pulse and blood pressure determinations, a state of complete circulatory adequacy. Yet to all appearances these reactors were in shock. Furthermore, the accelerated pulse rates observed as well as the restlessness was in keeping with that picture of surgical shock as ordinarily described.

In certain premedicated donors in Group I, it was possible to observe momentary heart stoppage during the initial stage of the reaction with concomitant momentary syncope provided the subject was not recumbent at the time. This phase was very evanescent and was followed immediately by full circulatory adequacy, yet these subjects remained prostrated, blanched, and restless for a prolonged period compared to that observed in blood donor syncope developing in non-premedicated subjects.

#### DISCUSSION

The confusion, restlessness and agitation of coramine premedicated reactors indicates the



presence in the syncope syndrome of what we have previously termed a "cerebral component". This component is usually masked by the unconsciousness that supervenes in the reactor but we have suspected its existence on another basis. For instance, careful questioning of reactors who lost consciousness revealed that they "noticed that everything was going black." Since such an occurrence was noticed they must still have been lucid at this time; an amblyopia apparently preceded unconsciousness.

Whether the explanation of the latter phenomenon lies in the greater sensitivity of the retina than the frontal cortex to anoxia (unlikely since the initial symptom of oxygen poisoning before the convulsive stage, is amblyopia<sup>14</sup>), or in a blocking of optic nerve impulses through sudden increase in intraorbital or intracranial pressures (transient manifestations of systemic acetylcholine intoxication), or whether some other mechanism is involved is not known at this time.

The mechanism of the amblyopia is an unrelated topic and mentioned here only in that it constituted one of a set of manifestations in syncope that led us to suspect the presence of an "idiopsychic factor"<sup>6</sup> operating apart from that of cerebral anemia in the production of unconsciousness.

We were trying to elucidate these factors when the report of Romano and Engel<sup>15</sup> along with the superb discussion by Alexander<sup>16</sup> appeared. Romano and Engel describe, in addition of the common variety of vasodepressor syncope, a form in which no circulatory inadequacy is apparent, which they ascribe to an hysterical conversion. While our point of view is necessarily incompatible in two respects with that of Romano and Engel, (1) in that they maintain a purely neurogenic engenderment of vasodepressor syncope while our own calls for a combination of neurogenic and humoral forces and, (2) since we have induced their second (circulatory adequate) type in an individual whom we presume would have reacted by a vasodepressor response in the absence of coramine premedication, solely by the institution of such premedication (a procedure that could hardly have altered the psyche) that their second type is not an hysterical conversion.

However, in designating a conversion status to certain types of syncope, Romano and Engel have introduced a valuable concept in that conversions are teleologic mechanisms and it is with classification of psychogenic syncope in the last category that we can definitely agree.

#### SYNCOPE AS A PHYSIOLOGIC EPISODE

The percentage of syncope reactors in donor groups from penal institutions is far lower than that observed in non-institutional groups. This

conclusion is not reached from the presently incorporated series—which is far too small for an exact statistical analysis—it follows from what has been remarked upon in the large number of penal institutions where, incidentally, the blood donor program has received whole-hearted support. The lower incidence of donor reactors in such institutions is not explained on the basis of age distribution of donors (younger individuals make up the bulk of reactors) nor does the "psychic conflict" factor, previously evoked, explain the difference. For in these institutions, equally pressing, if dissimilar subconscious motives, may actuate the voluntary blood donor. Actually the numbers of the psychologically and physiologically syncope predisposed type, frequently termed "vagotonics" are fewer in this group. The penologic significance of this fact is not our concern but medically it is important.

With the late Commander L. M. Rogers, USPHS, Senior Surgeon of the Federal Industrial Reformatory, who was analyzing the relationship of "accident proneness" to "delinquency", an attempt was made to determine the presence or absence of a correlation with syncope propensity. Statistically, little progress was made but clinically a rather surprising inference was reached; the type (or rather group of types) variously called "vagotonic", "thymico-adrenal" or "ectomorph" depending on the leanings of the classifier, are syncope prone, teleologically—it is their protective response to injury either actual or anticipated. Blood loss taboo being a component of the instinct of fear, the thalamus which takes control during such a situation has evolved a mechanism for coping with it. Ignoring the often erratic orders from that evolutionarily late usurper, the cerebral cortex, it floods the system with an acetylcholine-like substance, and channels through the splanchnic nervous systems the directions as to the sites at which the cholinokinetic\* hormone is to act. The heart action is held in abeyance by vagal effect and the peripheral arterioles and skin capillaries are constricted both for the limitation of possible peripheral bleeding and to further diminish the heart output and arterial blood pressure through arterio-venous dissociation and forward failure. By the resulting cerebral anemia, syncope is

\*The term "cholinokinetic" is introduced at this point to indicate that we have no certain knowledge of the chemical nature or pharmacodynamics of the parasympathetic stimulating substance that is found in the blood of humans under emotional stress. Whether it assists acetylcholine by inactivating cholinesterase like the cholinergic substances, eserine or physostigmine, or whether it can replace the choline derivatives in direct stimulation of interneuronal, neuromuscular and neuroglandular junctions like the cholinomimetics, histidine, guanidine, muscarine or pilocarpine is undetermined. "Cholinokinetic" is an inclusive term for both cholinomimetic and cholinergic substances. As will develop in a subsequent report on shock, its introduction is justified by its utility. Cholinokinesis is the state produced by the systemic action of cholinokinetic substances. It should not be construed to refer to the normal activity of synaptic and neuromuscular junctions.



induced and the organism is immobilized with the brain at the same hydrodynamic level as the heart. This is the position best suited for the functioning of the thalamically-controlled animal—the quadrupeds do not go into syncope.

A corollary of this hypothesis is that syncope would be a chain reflex designed to diminish the minute output of the heart and prevent death by hemorrhage. As a thalamic reflex whose general pattern, though undoubtedly modified as to detail by the activity of higher centers, is fairly established for the vagotonic; it is designed to accomplish a specified result and the organism depends on the essential realization of this end result.\*†

If the teleologic result is abrogated, either by undue interference of impulses from the cortical level in a function that properly belongs to the thalamus or by the maintenance of a high level of circulatory activity through some other means (improperly timed circulatory stimulation) when the physiologic goal is circulatory depression, the response may be a pathologic one.‡

It must be emphasized that in the construction of this concept, we are referring to a chain mechanism in the so-called vagotonic individual (syncope prone) and predicate for him a certain chain reflex pattern. An attempt will be made in future reports to elaborate a more generalized application of the role of cholinokinetic phenomena in the production of similarly teleologic responses in other types of individuals, and although other cholinokinetically engendered medical episodes (anaphylaxis, pyrogenic reactions) are likewise physiological responses, it is not to be assumed that they may not per se result in a serious morbidity or death to the individual. If the syncope syndrome is such a physiological mechanism it does not imply that its advent is medically inconsequential.

The recent link-up between diseases of thymus and myasthenia gravis has suggested by converse that the tragic termination of certain subjects having "status lymphaticus" might be examples of a severe cholinokinetic episode. For there is no reason to believe that the circulatory depression which is part of a physiologic mech-

anism may not be protracted to the point where irreversible changes result. Though we may anticipate from the law of frequency distribution that a small number of syncope instances per se will be extremely severe, it is difficult to believe, in those instances where severe shock follows "ordinary" syncope that there is not some unobserved pre-existent inorganic disease.

In fact, the most probable explanation of sudden death due to "syncope" is that such individuals have narrowed coronaries through which the circulation becomes interrupted during the cardiac inhibition attendant on the syncope syndrome. Two such instances in blood donors are known to the writer. But such instances, although they are ascribed to "shock", even in the present absence of a good definition of the latter do not point out the true relationship of the syncope syndrome to shock. A better understanding of this relationship follows by induction from the coramine premedication experiments.

In the ordinary sequence of psychogenic syncope, which Moon terms "primary shock" and Blalock calls "neurogenic shock", (either with, or more usually without a manifest convulsion) the patient swoons, becomes conscious, breaks out into a sweat and then feels better. He may be prostrated but the physiologic chain reflex has been carried to completion; recovery is in order and the patient realizes it. In all probability he has had such episodes before. He is no longer under emotional stress; no longer is there a strong element of fear. In fact on the appearance of the sweat, a feeling of relief may set in.

If on the contrary, unwarranted splanchnic sensory impulses continue to bombard the thalamus from a circulatory system that is supposed to be physiologically quiet, the episode is prolonged beyond its physiologic end. This alone may serve to sustain the psychosomatic sequence that approaches irreversibility when secondary shock is existent.

A similarity is noted in this sequence to that which occurs in seasickness where the continuous impingement of abnormally strong impulses from the semi-circular canals leads from a condition initially indistinguishable from the pallid phase of psychogenic syncope to protracted prostration and even to a condition approximating clinical shock.

#### THE RELATION OF SYNCOPE TO "SHOCK"

The "shock" phase of the syncope syndrome has been referred to as primary shock (Blalock<sup>7</sup>) or neurogenic shock (Moon<sup>8</sup>). The transition between "primary" and secondary shock is frequently but not invariably demarcated by a transient relief of the circulatory depression. However, the clinical picture of untreated shock

\*†The fact that we have postulated a humoral rather than strictly nervous actuation for the syncope syndrome does not vitiate its chain-reflex nature. We are prone to consider the components of reflex arc in terms of nervous elements but as an example of a primarily hormonal chain reflex, the menstrual cycle, dependent for its smooth sequence on the proper interaction of the follicular and luteal ovarian hormones with those of the anterior hypophysis may be cited. The flow of gastric, pancreatic, biliary and jejunal digestive juices in proper sequence, is another instance of humorally activated chain mechanisms.

‡By regarding the usual syncope reaction as a teleologic one, it fits into the same category as two other cholinokinetic viscerosomatic chain reflexes, laughing and crying. Like syncope, these are distinctly human teleologic responses, the purposeful suppression of which (again except possibly by the temporary vitiation of cortico-thalamic impulses in those instances where the response takes on morbid magnitudes) can not be regarded as of universal therapeutic justification.



is usually one of progression from the syncope episode to circulatory collapse.

If the view be taken that syncope is the result of a physiologic mechanism, it is desirable to reconcile this thesis with its transformation into an evidently pathologic state. For this case waiver is made of the instances cited above, e.g., status lymphaticus; coronary occlusion. To trace the pathogenesis of the transformation, it is necessary to define "shock".\*\*

For the present purpose an attempt will be made to evolve an etiologic definition of shock and this will necessitate the elaboration of four premises, all of them essential to the final definition and of additional interest inasmuch as these premises are actually legitimate conclusions from observation.

#### I. Shock Is a Condition Whose Recognition Is Solely a Matter of Clinical Appraisal.

One by one, the validity of the vaunted criteria have been swept aside and judgment based on consideration of the organism as a whole suffices for a determination of the existence of the state and the degree of severity of shock. War-time experience has shown that the skin may be clammy or dry, pulse accelerated or slowed, depending on individual reaction; even hemoconcentration once thought to be the inevitable consequence of the depressed circulation in non-hemorrhagic shock is not a dependable laboratory finding—hemodilution occurs not infrequently. Circulatory inadequacy is probably the least variable accompaniment of the shock state, but;

#### II. Pulse and Blood Pressure Determinations Give No True Index to the Degree of Systemic Circulatory Inadequacy.

The reaction of coramine premedicated subjects described above is considered, clinically, to be one of shock. Yet pulse rate and quality appeared to be normal. Can then shock coexist with circulatory normality?

The excursion of the tactile pulse, for centuries the criteria of circulatory state, is proportional to the pulse pressure. This parameter multiplied by the pulse rate gives an index to the minute output of the heart. Other factors being constant, the minute output is a measure of circulatory adequacy but certain conditions exist in which these factors are abrogated. For instance, under certain pathologic conditions (patent ductus arteriosus; arteriovenous aneurysm) the venous return to the heart may be such as to implement even an augmented minute output, yet because the circulation is shunted through abnormal channels in these conditions,

many organs do not receive an adequate blood supply. An adequate circulation is one by which all capillary beds would be supplied.

It is probable that the often reported splanchnic engorgement present in shock and once thought to be the instigator of shock, acts as this type of shunt and may be the cause of deprivation to certain of the somatic structures. This would hardly be the explanation in our subjects because the radial pulse is strong. However, we must predicate that the arterio-venous connection in this instance is through unusual channels, for the skin capillaries are markedly constricted. That a large proportion of the capillary circulation is normally carried through the skin can only be appreciated by watching the effect on the rate of venous blood flow by the application of ice bags to the forearm of a blood donor.††

#### III. Though Simple Criteria For Its Recognition Are Not Attainable, Circulatory Inadequacy Is the Sine Quo Non of Shock.

If by circulatory adequacy one means that which supplies the requirements of all organs, then we may accept this axiom as applicable to all forms of those reactions which have as yet defied primary etiologic definition but which have nevertheless been lumped together by astute clinical appreciation as "shock" (anaphylactic, psychic, traumatic, toxic shock). It is now proposed to render such a primary etiologic definition on the basis of a premise derived from IV.

#### IV. Both Syncope and Shock are Cholinokinetic Phenomena.

Regardless of whether their incitement is through an irritable carotid sinus or through psychic hyperventilation and carbon dioxide deficit, the localized or generalized vasodepression which results in syncope or shock is a cholinokinetic phenomenon. This is the case whether neurogenic or hormonal instigations are held to be responsible. Because of previously mentioned considerations we tend to the view that a hormonal basis exists for the various autonomic manifestations though admitting the possibility (and even the likelihood) of direct nervous influences to the end organs showing these manifestations. A preponderantly humoral cholinokinetic nature of the autonomic phenomena seen in shock is bespoken by each of current theories of the humoral engenderment of shock even though the evidence compiled for each ascribes a separate autochthonous substance

††That the marrow cavities of the long bones may collaterally complete arterio-venous circulation is concluded from the fact that venous return is noted after shutting off the arterial circulation by the application of a sphygmomanometer cuff at 50-70 mm. above the systolic pressure.

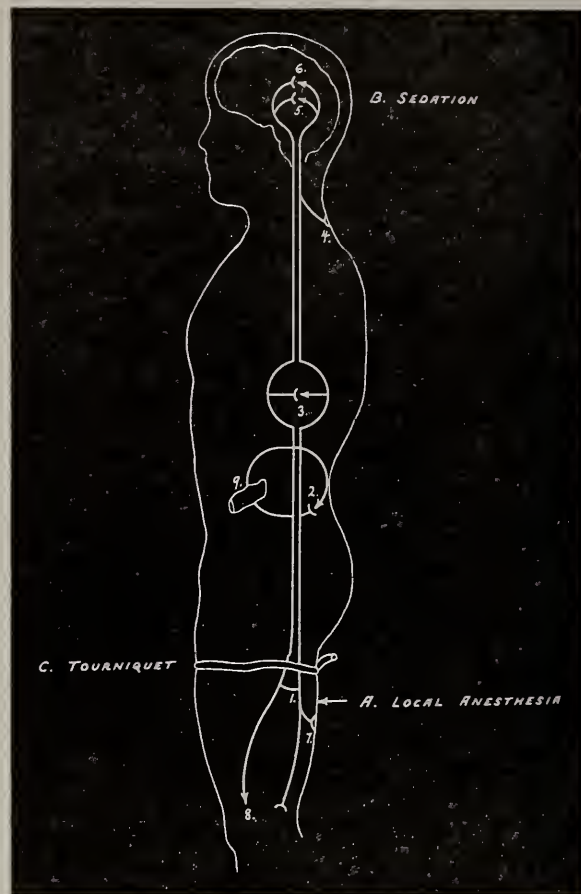
\*\*See Editorial J.A.M.A.

(either histamine, Dale: choline ester, Barnard: or epinephrine, Freeman) the role of the "toxic" factor in shock.††

"Depressor" substances have been found in the circulating blood in shock (toxic shock—Harmon and Harkins<sup>19</sup>); and powerful cholinokinetic substances on administration will produce shock. In fact, the latter seems to depend more on the type of person to whom administration is made than does the exact chemical identity (whether choline ester, epinephrine, histamine or guanidine derivatives). The last mentioned is apparently a cholinomimetic (it has no antiesterase properties but is effective in the relief of myasthenia gravis); while the administration of guanidine derivatives usually causes tetany, studies on hyperventilation indicate a close relationship of the latter with the syncope syndrome.\*§ Cyanamide (carbimid) which is stereo-chemically and pharmacologically closely related to guanidine profound shock in humans and rats.

The cholinokinetic nature of guanidine derivatives gives an explanation of the shock produced by muscle crushing injuries, a clinical condition which can be counterparted experimentally by either the injection of minced muscle or the peritoneal implantation of reconstituted desiccated muscle.<sup>19</sup> The latter is a depot source of derivatives of histidine (carnosine) and guanidine (creatine, phosphocreatine). In this instance one may predicate the transition from syncope (primary shock) as due to a sustained cholinokinesis imposed upon the original neurogenic or humoral vasodepressor episode.

This seems to be the common denominator underlying all those conditions clinically classified as "shock" (Table II). A primary cholinokinetic episode, usually psychogenic syncope from which spontaneous recovery is not complete because of the persistence of cholinokinetic influences which maintain the circulatory depression. The latter may be of nervous origin by axon or more centrally circuited reflex from and back to the injured organ; by neuro-humoral reflex from the seat of the disturbance to the higher centers with a continued production of acetylcholine; by the direct liberation of cholinokinetic substance from the site of injury itself; or by the liberation of bacterial products (known



Legend for Figure I. The nervous reflex arcs maintaining cholinergesis in shock-like states resulting from (for example) crushing leg injury.

Axon reflexes over (1) from the site of injury (7) cause vasodilation at (8) facilitating the absorption of cholinergic tissue disintegration products. The vasodilation is further enhanced by reflexes over the splanchnic (2) and spinal somatic (3) arcs. If visceral trauma exists (9) the latter amplifies (2) and (3). Ascending impulses from (7) and (9) ascend to the cerebrum where they cause cortical (6) and thalamic (5) excitation; the latter may be fortified by impulses coming from the labyrinth or carotid sinus. (For this reason the position of transportation of an individual, in shock must be borne in mind.)

The factors which help to abrogate shock are (A) local anesthesia which cuts off some of the impulses causing higher center excitation (B) tourniquet (or amputation) which limits the amount of cholinergic material originating from the injured area. Sedation (C) by blocking the reflex arc through the higher centers as well as reducing the excitability of the cortex and thalamus also serves to break the vicious circle that results in irreversible shock.

Because of the variable effectiveness of either (A) (B) or (C) in various instances of shock various mechanical, humoral and nervous theories of the genesis of shock have been advanced. Actually no exclusive theory is a correct one, each factor unquestionably plays a role.

to be cholinokinetic through their pyrogenic effects).

Figure I illustrates the multiplicity of pathways of reflexly sustained cholinergesis in shock following muscle trauma. It indicates why a number of expedients have some degree of proved efficacy in the limitation of this type of shock. Mere local nerve block (A) (first advocated in the anoci-association technique of Crile<sup>20</sup> and later confirmed by Hays and Swingle) serves to abolish axon reflex and the sensory impulses activating both the vagal reflexes and the hypo-

††The ordinary practice of separating the "autonomic" drugs into "cholinergic" and a presumably antithetic "adrenergic" category is merely a terminologic expedient; it has little basis in pharmacodynamic fact and physiologically, it is misleading. The "adrenergic" drugs (paradrine, amphetamine, privine and ephedrine) as well as epinephrine itself have well marked parasymphathomimetic action, e.g., they may be used interchangeably with the "cholinergic" drugs (prostigmin, guanidine, creatin) in the treatment of myasthenia gravis. Epinephrine is a drug in whose action the nicotinic effects of the choline esters predominate.

\*§Actually there is no irreconcilability with hyperventilation alkalosis and the cholinokinetic theories of the engenderment of the syncope syndrome, since CO<sub>2</sub> deficit potentiates the action of the "parasymphathomimetic" drugs.



TABLE I  
A COMPARISON OF SYMPTOMS IN SYNCOPE REACTORS AND IN CORAMINE  
PREMEDICATED BLOOD DONATION REACTORS

|                       | Attitude              | Pallor          | Pulse                           | Blood Pressure                        | Skin                           | Duration        |
|-----------------------|-----------------------|-----------------|---------------------------------|---------------------------------------|--------------------------------|-----------------|
| Premedicated Reactors | Agitated or Restless  | White           | Bounding Normal or Elevate Rate | Systolic Elevated Diastolic Unaltered | Dry                            | Hours           |
| Control Reactors      | Apathetic or Listless | Grey "Greenish" | Usually Feeble Slow             | Depressed                             | Clammy or Markedly Diaphoretic | Usually Minutes |

TABLE II

| Type of Shock | Primary Source of Cholinokinetic Material (Initiating) | Secondary Source of Cholinokinetic Material (Sustaining) | Nature of Sustaining Cholinokinetic Material |
|---------------|--------------------------------------------------------|----------------------------------------------------------|----------------------------------------------|
| Psychogenic   | Thalamus or Hypothalamus                               | Thalamus or Hypothalamus                                 | Acetylcholine                                |
| Atopic        | Sensitizing Agent                                      | Sensitized (shock) Organ                                 | Acetylcholine and/or Histidine               |
| Traumatic     | Thalamus or Hypothalamus                               | Injured Organ                                            | Histidine and/or Guanidine Derivatives       |
| Toxic         | Thalamus or Hypothalamus                               | Bacterial                                                | Bacterial Toxin or Organic Cholinergics      |
| Erethistic    | Thalamus or Hypothalamus                               | Alimentary Canal                                         | Ethyl Alcohol                                |

thalamic acetylcholine producing center. Barbi-  
tal sedation (B) counteracts shock by raising the  
threshold over which these reflexes must take  
place. And finally constriction (C) of the limb  
or its amputation eliminates the injured mem-  
ber as a source of cholinokinetic substance.

The example of circulatory shock from muscle  
crushing injury is elaborated because it illus-  
trates the principles underlying the pathogenesis  
of all types of circulatory shock. The experi-  
mentally demonstrated methods of combating it  
are cited not in advocacy of any form of treat-  
ment but to adduce evidence, on therapeutic  
grounds of the validity of the general definition:

Circulatory shock is a condition arising in  
those specially predisposed individuals who un-  
der the stimulus of profound protracted cholin-  
ergesis react to the latter by localized or general-  
ized circulatory inadequacy.

It will be noted that no qualification has been  
made in the definition as to acuteness or gravity.  
The omission is on purpose. It is believed that  
certain forms of "neurocirculatory asthenias"

may be chronic conditions comparable to circu-  
latory shock. In a subsequent report an attempt  
will be made to show that circulatory shock may  
represent only one of the protean forms of  
cholinokinetic reactions.

SUMMARY AND CONCLUSIONS

1. Premedication with orally administered  
coramine is an unsuitable procedure for the pro-  
phylaxis of blood donor syncope. Such premedi-  
cation converts the latter into an aggravated  
form resembling surgical shock.
2. On the basis of observations made on pre-  
medicated blood donor reactors, it is concluded  
that psychogenic syncope, like risibility and  
lacrimosity, is a distinctly human cholinergic  
chain reflex with a definite teleologic end.
3. The relationship of psychogenic syncope  
("primary shock") to surgical or medical  
("true") shock is discussed and an hypothesis  
is developed to explain the latter on the basis  
of profound sustained cholinergesis leading to  
circulatory inadequacy.
4. The presence of the latter feature; the

sine quo non of shock, must be evaluated by clinical appraisal since it may coexist with an overtly normal pulse and blood pressure.

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I am strongly of the belief that the rapid decline in tuberculosis in this country during the last two decades has been due in no small part to the control of bovine tuberculosis. I believe this applies to the mortality, morbidity, and certainly to the infection attack rate. The decrease in the incidence of tuberculin reactors among children has been phenomenal; in fact, we now have whole counties where not more than five to eight per cent of the senior students in high school react to tuberculin test.—J. A. Myers, M.D., *Am. Rev. of Tuber.*, Dec., 1944.

## Infectious Mononucleosis

Although infectious mononucleosis is a relatively common disease it is often overlooked probably because of its varied clinical picture.

#### SYMPTOMS IN ORDER OF FREQUENCY

|               |                         |
|---------------|-------------------------|
| Headache      | Pain in neck            |
| Fever         | Nervousness             |
| Sore Throat   | Abdominal Pain          |
| Tender Glands | Pain on Moving Eyeballs |
| Constipation  | Weakness                |
| Chills        | Vomiting                |
| Malaise       | Sore, bleeding gums     |
| Backache      | Loss of weight          |
| Coryza        | Cough                   |
| Irritability  | Hoarseness              |
| Fatigue       | Photophobia             |
| Sweats        | Jaundice                |
| Anorexia      | Diarrhea                |
| Dizziness     | Arthralgia              |
| Nausea        |                         |

#### PHYSICAL FINDINGS IN ORDER OF FREQUENCY

|                     |                       |
|---------------------|-----------------------|
| Fever               | Enlarged Tonsils      |
| Enlarged Glands     | Membranous Angina     |
| Posterior-Cervicals | Enlarged Spleen       |
| Submaxillary        | Puffiness of Eyelids  |
| Subangular          | Abdominal Tenderness  |
| Axillary            | Enlarged Liver        |
| Epitrochlear        | Stiffness of Neck     |
| Inguinal            | Peritonsillar Abscess |
| Femoral             | Jaundice              |
| Submental           | Rash                  |
| Tender Glands       | Herpes Labialis       |
| Throat Injected     | Enlarged Thyroid      |

It has been found that the majority of patients with infectious mononucleosis have sheep-cell agglutinins in their serum in a titre of at least 1:160. This test becomes positive about four or five days after the onset of the illness, and the titer increases, reaching a peak by the fourth week.

A Paul-Bunnell test should be performed in the following cases:

- I. Individuals with unexplained lymphocytosis or glandular enlargement.
- II. Individuals with positive agglutination tests (Widal, etc.) without cultural confirmation.
- III. Individuals with false positive Wassermann reactions.
- IV. Individuals with unexplained acute abdominal conditions.
- V. Individuals with enlarged spleen of unexplained cause.
- VI. Patients with atypical forms of conjunctivitis or puffy eyelids.
- VII. Apparent cases of (a) infectious hepatitis, (b) Vincent's infections, (c) aphthous stomatitis, (d) benign lymphocytic meningitis, and (e) agranulocytosis.

—W. D. Paul, M.D., Iowa City, Iowa; Jr. of Ind. State Med. Assn., Vol. 38, No. 11, Nov., 1945.



# Surgical Treatment of Gastric and Duodenal Ulcer

M. M. ZINNINGER, M.D.\*

**S**URGICAL treatment of gastric or duodenal ulcer should be undertaken only after the development of certain complications, or after failure to obtain cure or relief of symptoms by proper medical management. The overwhelming majority of ulcers are therefore to be looked upon as medical problems, and the surgeon sees or should see only a small proportion of the total number. The complications which ordinarily lead to surgical intervention are: acute or subacute perforation, obstruction, severe bleeding, and intractable pain or persistent failure of the ulcer to heal.

## PERFORATION

Perforation is one of the most acute and dramatic accidents in medical practice. In spite of the fact that the signs and symptoms are usually clear-cut and characteristic, the diagnosis is sometimes overlooked, and fatal loss of time in instituting treatment may ensue. It is therefore important that the first physician who sees the patient be able to recognize the condition. The typical story is one of sudden, acute pain usually localized to the epigastrium. The pain is severe, continuous rather than intermittent or cramp-like, and may be associated with weakness, faintness or even shock. If shock develops, it is often of short duration and may disappear spontaneously. The patient may or may not have symptoms or signs of ulcer prior to the acute onset. In many instances absolutely no history suggestive of ulcer can be elicited. Not infrequently there are prodromal signs such as vague indefinite pains for some hours before the acute accident.

On examination the patient may be doubled up with pain, but often lies quietly on his back with the legs flexed. The pulse is usually rapid, may be weak, and there may be slight cyanosis. In the first hours, the abdomen typically is scaphoid or retracted, with marked muscle spasm so that the entire abdomen feels rigid to the palpating hand. The point of maximum tenderness is usually in the epigastrium but may be in the right lower quadrant so that rupture of the appendix may be considered as a possible diagnosis. On percussion, there is tenderness and tympany, so that even the area of normal liver dullness may be diminished or absent.

In the presence of a retracted abdominal wall, the absence of normal liver dullness suggests

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that there has been escape of free gas into the peritoneal cavity. When the abdomen is distended, decrease in liver dullness is not so significant a finding, as it may then be due to dislocation of the liver upwards. Not infrequently there is tenderness in the region of the shoulder, due presumably to the escape of irritating fluid underneath the diaphragm with pain referred upwards through the phrenic nerve to the region of the trapezius muscle. On listening to the abdomen with a stethoscope, there is found to be an absence of the usual normal peristaltic sounds. The temperature is often subnormal for one to two hours after the accident but then rises slightly above normal. The white blood count is often elevated.

## THE X-RAY

The most important diagnostic procedure, after a careful physical examination of the abdomen, is a flat X-ray of the abdomen with the patient either semi-erect or in the left lateral decubitus. The purpose is to detect the presence of the free gas in the peritoneal cavity. The demonstration of free gas in the peritoneum is an important positive sign, as it is diagnostic of the perforation of hollow viscus, but failure to find gas by X-ray does not exclude that diagnosis, for insufficient gas may have escaped to be demonstrable.<sup>1</sup> In our experience sufficient free gas to show in the X-ray is present in about 60 to 65 per cent of the cases of perforated ulcer, and its demonstration is therefore an important diagnostic aid.

## PREOPERATIVE PREPARATION

The diagnosis having been made, prompt operation is indicated, as it has been shown repeatedly that the earlier operation with closure of the perforation is performed, the lower is the mortality rate. While the operating room

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is being prepared, the patient should receive pre-operative treatment, and if his condition is not good, the operation may be delayed for an hour or more to improve his general state. Ordinarily the preparation consists of intravenous administration of fluid, the starting of continuous gastric suction, and the giving of chemotherapeutic drugs. The intravenous fluid is usually 5 per cent solution of glucose in saline or distilled water, though it may be plasma or blood if the patient is in shock.

The continuous gastric suction may be started before operation, during the operation, or after completion of the operative procedure. It is usually best to start it as soon as the diagnosis is made, to prevent further escape of fluid from the stomach into the peritoneal cavity. The use of chemotherapeutic agents has undergone a number of changes in a relatively short period of time. For some time our routine procedure was to dust five to eight grams of sulphanilamide into the peritoneal cavity at the completion of the operative procedure, but we have gradually changed to administration of one of the sulpha derivatives, usually sulphadiazine, by intravenous or subcutaneous injection. For a while this was given postoperatively, but more recently has been given preoperatively as well. It is probably desirable to give penicillin also, but up to the present time we have not been able to use this drug regularly.

#### THE ANESTHETIC

The anesthetic agent to be used varies at different clinics. We prefer inhalation anesthesia with cyclopropane or nitrous oxide and ether, but spinal anesthesia is used at times. The operation of choice, we believe, is simple closure of the ulcer. During the past 20 to 25 years, we have tried various methods, such as simple closure, excision and closure, with and without gastro-enterostomy, partial resection, etc., and have come to the conclusion that simple closure is attended by the lowest mortality and gives satisfactory results. It is, therefore, the method used routinely, although occasionally due to some special condition other methods may be used.

The closure is usually made by several interrupted Lembert or Halsted mattress sutures of silk, which may be reinforced by tags of omentum, though if there is much induration so that inversion can not be accomplished, only a piece of omentum or other peritoneal fat is sutured over the opening as a patch according to the method advocated by Graham.<sup>2</sup> The fluid in the peritoneal cavity is sucked out as completely as possible, but ordinarily no drains are placed. The abdominal wall is closed with through-and-through wire sutures as described by us some years ago.<sup>3</sup>

The ordinary postoperative treatment is con-

tinuation of gastric suction until peristalsis returns, intravenous alimentation, and the use of chemotherapeutic agents as indicated by the patient's progress. The postoperative complications to be watched for are: (1) infection of the abdominal wound, (2) peritonitis, (3) postoperative atelectasis or pneumonia, and (4) intra-abdominal abscess, especially subphrenic abscess.

The second complication of ulcer which calls for surgical intervention is pyloric obstruction. This is usually secondary to a duodenal ulcer of long standing, with periods of exacerbation and remission, the obstruction being due to scarring and fibrosis at the pylorus. The symptoms may be indistinguishable from carcinoma of the pyloric end of the stomach. The prime symptom is vomiting, often of considerable amounts, and of food eaten some time before, with or without pain, and usually without much nausea. The history of long-standing duodenal ulcer with vomiting superimposed is typical and almost diagnostic. Considerable loss of weight has usually occurred, and the patient may be weak, and show evidence of depletion of proteins, chlorides and vitamins.

On physical examination the only finding of note other than loss of weight, may be a dilated, tympanitic stomach, with succussion splash and visible peristalsis. The X-ray is usually diagnostic. Often there have been previous X-ray examinations which have shown direct or indirect evidence of duodenal ulcer. Now there is found a large sac-like stomach often without any striking peristaltic waves, and with obstruction at the pylorus, with or without demonstration of the crater of an ulcer. There is considerable gastric retention of the barium meal 12 to 24 hours after ingestion. On passage of a stomach tube a large amount of foul-smelling material can usually be obtained. Gastric analysis at this stage is unsatisfactory, as there is too much retained food for accurate study to be made.

When this condition has been reached, operation is usually imperative if cure is to be obtained, but it should be carried out only after adequate preparation. This consists of intravenous alimentation, the particular fluids and the amounts used depending on the state of the particular patient. Chlorides and proteins are usually depleted and the blood count may be low, so that some blood or plasma is usually desirable. Modern methods of intravenous feeding allow the giving of carbohydrates, proteins and salts without the necessity of using plasma. Several suitable preparations are already available commercially and others will undoubtedly appear. We have used with satisfaction Stearn's "Amino-acids" and Mead-Johnson's "Amigen". A particular effort should be made to replace depleted proteins as patients with low protein levels may heal slowly and not recuperate rap-



idly. A patient who has been vomiting and become dehydrated may show a relatively normal plasma protein, but this may drop to a low level when satisfactory hydration has been reached.

While an attempt is made to attain relatively normal levels of blood cells, proteins, and electrolytes, local treatment of the dilated atonic stomach should be carried out. In our experience the best method of doing this is to drain the stomach continuously with tube suction drainage for 8 to 12 hours. Then the tube is removed and the patient is given a liquid diet with frequent feedings. A large stomach tube is then passed once or twice a day, at approximately the same hour each day, and preferably about two hours after a feeding. The amount of material obtained should be measured and charted.

This discontinuous drainage allows the absorption of a certain amount of food and fluid and at the same time empties the stomach at least once a day, gets rid of accumulated food and allows the gastric wall partially to regain its tone. Usually the amount of retention decreases considerably under this management. Often a week or more of such therapy is required to get the patient, and the stomach itself into a condition sufficiently near normal to undertake the operation.

#### WHAT PROCEDURE?

Just what procedure should be used depends on individual conditions. Usually resection of the ulcer, and of the distal two-thirds to three-fourths of the stomach is the procedure of choice, though occasionally, a simple gastroenterostomy should be used. It is my belief that the latter procedure should be used in patients in advanced years, those with contra-indication to an extensive abdominal operation, and those who have a low free gastric acidity. For most other cases resection and anastomosis is the more satisfactory method.

In some of these patients, especially those who have been severely starved due to high grade obstruction, a small mushroom catheter is placed in the jejunum after completion of the anastomosis, and brought out through a stab wound in the left side. Through this tube, water may be given 8 to 10 hours after operation, and peptonized milk and other liquid foods within 24 hours. We have used as a rule the mixture known as the Scott-Ivy jejunal feeding.<sup>4</sup> It has been a great help in the postoperative care of starved patients and reduces very materially the amounts of intravenous fluids which would otherwise be required.

#### BLEEDING

Bleeding from an ulcer is another complication which may require operative treatment. As is well known there is slight oozing at times from

almost any ulcer, so that occult blood is usually present in the stools more or less continuously. This type of bleeding is not in itself an indication for operation.

There is another sort of bleeding which occurs much less frequently and which, in my opinion, is an indication for operative intervention. This is the massive hemorrhage which is associated with weakness, faintness or even loss of consciousness, vomiting of blood, or the passage of large amounts of blood in the stools. Such bleeding comes as a rule from erosion of a large artery in the base of the ulcer. Such arteries are usually sclerotic with relatively rigid walls, and this condition, plus the fact that the artery is held in dense scar tissue, prevents retraction of the open end of the artery which is nature's method of controlling such bleeding. Bleeding ceases when the blood pressure drops to a sufficiently low level or when a blood clot forms in the open end of the vessel. Such stoppage may only be temporary, as the digestive juices may dissolve the clot and allow bleeding to start anew. When one sees the pathologic process which is taking place, one is amazed that bleeding ever ceases spontaneously. In many instances it does cease, in others it intermits, while in still others it persists, until death from loss of blood ensues.

The medical and surgical management in cases of this sort is exceedingly difficult and may tax one's ingenuity to the utmost. If it were possible to tell at the onset which patients would cease to bleed, and which would continue, the matter would be simple. One would treat the first group by conservative methods and operate on the second group as soon as they could be gotten into suitable condition by massive blood transfusions.

Still another factor may complicate the picture, and that may be the uncertainty as to whether the patient is bleeding from an ulcer. This is particularly true in patients such as those coming to a general charity hospital. Nothing may be known about the patient's background and no history may be obtainable for many hours, and then it may be entirely unreliable. Other causes of bleeding therefore have to be considered, the commonest one being oesophageal varices, superficial gastric erosions, aneurysm eroding into the oesophagus, and benign or malignant tumors of the stomach, or tumors eroding the stomach. If ulcer is known to exist from previous history or X-ray, the problem is much simplified. In such instances, my inclination is to operate promptly unless bleeding ceases within a short time.

It is known that bleeding is less likely to cease spontaneously in individuals in the older age groups, and also that the mortality rate

risers sharply with recurrent hemorrhages, so that if an individual bleeds, stops and then bleeds again, the outlook without operation becomes more grave. In cases of doubt as to the source of bleeding we have been considerably helped by certain X-ray studies, although these have to be done carefully owing to the poor general condition of the patient and to the danger of restarting bleeding which has temporarily ceased. Study of the stomach and duodenum with a small amount of barium by the Hampton technique<sup>5</sup> has given a positive diagnosis of ulcer in some cases, although in others it has led to an incorrect diagnosis.

In general, it is my opinion that it is safer to operate when in doubt, than not to operate. We have saved a number of lives by operation during the bleeding stage, but have had no patients die as a result of the operation when some condition not amenable to operation was found. For example, a patient was operated upon for bleeding from a supposed ulcer and no ulcer was found. He continued to bleed, and died 36 hours after operation. Autopsy disclosed an aneurysm eroding into the oesophagus.

The procedure to be carried out at the time of operation varies with each individual case. Gastric resection has been carried out in a number of cases even in patients who have gone to the operating room with blood counts below two million red blood cells per cmm. In some gastric ulcers, bleeding has been controlled by ligating vessels around the ulcer from outside the stomach. This method is unsatisfactory in duodenal ulcer as there are too many collaterals, and ulcer on the posterior wall is inaccessible from without. Therefore, in bleeding duodenal ulcer, either resection should be done, or the duodenum should be opened and suture placed directly around the bleeding vessel. The duodenum can then be closed.

For patients who have had one or more serious hemorrhages from which they have recovered spontaneously, it is my belief that operation during an interval should be carried out to prevent further bleeding. The operative procedure indicated is removal of the ulcer plus subtotal gastrectomy, removing two-thirds to three-fourths of the stomach. This proves very efficacious in the vast majority of patients.<sup>6</sup>

#### PERSISTENT SYMPTOMS

The final group of patients with ulcer in which surgical treatment should be carried out are in those with persistent failure of the ulcer to heal, or with persistent symptoms. As is well known, symptoms of ulcer tend to be remittent, the patient having frequent exacerbations and remissions. Healing and reactivation can often be seen by X-ray or by gastroscopy if the ulcer is

in the stomach. Ulcer of the stomach and of the duodenum have to be considered in somewhat different categories when the question of healing is under consideration, because a non-healing ulcer of the stomach may be a carcinoma. Therefore any ulcer of the stomach which fails to heal completely within four to six weeks of proper and adequate treatment should probably be treated by operation.

With duodenal ulcer, it is a question of failure to obtain relief of symptoms by medical treatment which may lead to consideration of surgical intervention. No hard and fast rule can be drawn in making the decision. Most patients can either be completely relieved of their symptoms or have them greatly alleviated by proper operation, while the operative risk is not great. It is only fair that the patient should be given this information, so that he can decide whether he wishes an operation. Few will submit to operation who are getting along reasonably well most of the time, but in others who are never entirely well operation may bring great comfort. The best results in patients of this sort are obtained by subtotal resection and anastomosis, as gastro-enterostomy or pyloroplasty with or without resection of the ulcer is usually less effective. Our routine procedure is resection of the ulcer, plus two-thirds to three-fourths of the stomach with a Polyá or Hoffmeister type of anastomosis.

In conclusion, I should like to emphasize that peptic ulcer is primarily a medical disease, which becomes surgical only after the development of certain complications. These have been separately described and the general treatment outlined.

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#### Prompt Diagnosis

Prompt diagnosis of tuberculosis is important to the patient, family and community. Every suspected case should be cleared of suspicion as quickly as possible by being proved innocent or guilty of harboring the disease. The Modern Attack on Tuberculosis, Henry D. Chadwick, M.D., and Alton S. Pope, M.D.



# Perforation of the Sigmoid Colon by an Ingested Toothpick

FREDERICK G. HAMILTON, M.D., and JOHN F. CORRIGAN, M.D., Cleveland

THE following case is presented due to the type and site of the lesion, a review of the literature showing this particular case to be rather unusual.

**Case History:** The patient was admitted upon the surgical service of St. Alexis Hospital with the chief complaint of a dull pain in the left inguinal region and lower left abdomen for the past two weeks. Shortly after the onset of the pain, the patient became conscious of a mass in the lower left abdomen. There was no history of nausea or vomiting, and the patient's bowel habits had undergone no change. There was no history of blood in the stool, nor had there been any previous surgery. The only part of the patient's past history which caused concern was a two months' history of polyuria, polydipsia and nocturia, and a loss of appetite.

**Physical Examination** revealed a well-nourished, white male, age 61. Palpitation of the abdomen revealed a mass in the lower left quadrant, at the level of, or just below the antero-superior spine of the ileum. Roughly, the mass measured 8-10 cm. in diameter, was very hard and immobile, and seemed to be attached to the anterior abdominal wall. The mass was moderately tender to palpation, other abdominal findings being normal. Examination revealed no lymphatic enlargement whatsoever, and rectal examination showed only a slightly enlarged prostate.

**Laboratory Examination:** Urinalysis showed a specific gravity of 1.017, albumin —  $++$ , sugar — neg., acetone — neg., blood had a hemoglobin of 13.2 gm./100 cc., red blood count of 4,750,000, white blood count of 10,500, and blood sugar was 79 mgms. per 100 cc.

**X-Ray Examination:** Roentgen examination by use of a barium enema showed numerous diverticuli of the descending and sigmoid colon, being most prominent in the lower descending and proximal portions of the sigmoid. No evidence of intrinsic tumor was seen; however, a large mass was noted in the lower left abdomen in close relation to the upper sigmoid colon. There was no evidence of direct communication between the colon and the mass.

**Diagnosis:** A preoperative diagnosis of a ruptured sigmoid diverticulum was made.

**Surgery:** The patient was prepared for surgery, having been given 100 gr. of sulfasuccidine in the previous 24 hours, and typed and cross-matched for transfusion. With spinal anesthesia, an exploratory laparotomy was performed as follows:

The abdominal cavity was entered through a low, left pararectus incision, slightly medial to the mass. It was readily located and was found firmly attached to both the sigmoid colon and the abdominal wall. The induration of the abdominal wall was so severe that it appeared to be a part of the mass. As a small wedge shaped piece was removed for biopsy, a portion of wooden toothpick  $2\frac{1}{2}$  inches was found within the lesion. No pus or fluid was seen. The mass was then

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brought out as much as possible into the incision as in a Mikulicz procedure, and the peritoneum and abdominal wall was closed about it. The extruding portion was then covered by vaseline gauze. The patient was returned to his room in good condition.

Subsequent examination of the biopsy tissue by the department of pathology showed it to be acute and chronic granulomatous inflammation of fibroadipose tissue with foreign body reaction.

Postoperatively, the patient was given  $7\frac{1}{2}$  gr. of sulfathiazole and  $7\frac{1}{2}$  gr. of sulfanilamide every four hours for seven days. Upon the second postoperative day, the patient's temperature went to  $102^{\circ}$  but returned to  $99^{\circ}$  upon the third day and remained normal.

**Postoperative Course:** In addition to whole blood the patient was supplied with 2,000 cc. of fluids parenterally during the first postoperative 24 hours, after which sufficient fluids by mouth were allowed.

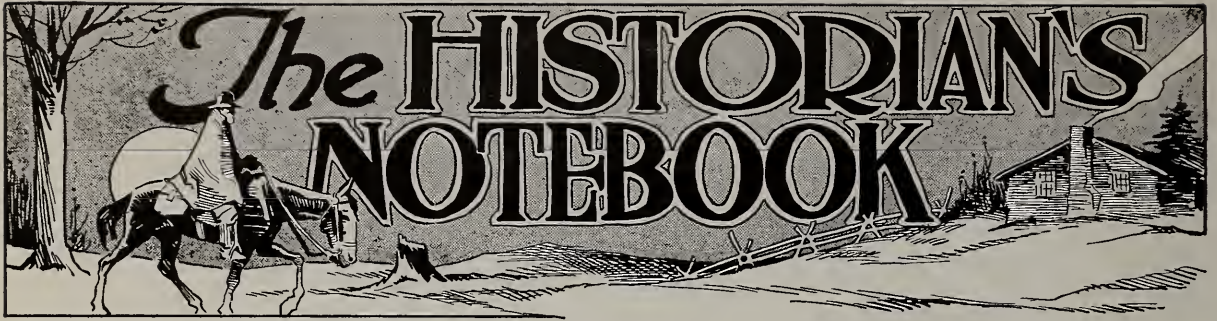
Daily dressings revealed constant purulent drainage of considerable amount. The drainage continued for 2 weeks while the mass became progressively smaller. Dakin's tubes were inserted about the mass and irrigations every four hours were instituted with a solution of penicillin (1,000 units to 10 cc. sterile  $H_2O$ ). More drainage and a smaller mass resulted from this procedure. During the last two weeks of hospitalization, the patient was ambulatory, and was then discharged to his family physician one month following surgery.

At the present writing, the patient has returned to his work. The mass is very small and there is still a very slight drainage necessitating a dressing twice a week.

## DISCUSSION

A review of the literature upon cases of this nature shows that symptoms are, as a rule, slow in onset. In the majority of cases, dull pain marks the onset of symptoms, followed by the discovery of a mass at the site of discomfort. In a number of cases, the mass was the first thing to be noted by the patient.





Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

## An Eastern Doctor Visits Cincinnati

PHILIP D. JORDAN, PH. D.

(Continued from the December issue.)

10 o'clock P.M.

I have, this moment, returned home from Mr. Stetson's, where I passed the evening, pleasantly and profitably, in a small *conversazione* of ladies and gentlemen. There was no *badinage*, or frivolity. The conversation was chiefly of a literary cast—free, easy, entertaining, instructive, without restraint, and without formality. If this thought I to myself, be a fair sample of the state of society here, it must have assumed a higher character than it has attained in many older portions of the Union. Indeed, if I may be allowed to judge from what I have myself witnessed, I must say, that Cincinnati, so far as relates to refinement of manners, intellectual culture, and hospitality to strangers, is more like Boston, than any other city in the United States, of which I have any personal knowledge. It resembles the metropolis of New England, too, in another important particular, viz. the attention it pays to the education of its youth, and the diffusion of useful information among the different classes of its citizens.

Here I find a "Mechanic's Institute," with a competent philosophical apparatus, imparting scientific knowledge to the laboring portions of the community, by means of gratuitous lectures. Here is an "Academy of Natural Science," in whose Hall may be seen a good collection of plants, shells, minerals, fossils and birds. Here is a "Literary Institute, and College of Professional Teachers, whose object is to promote, by every laudable means, the spread of knowledge, in regard to education, by aiming at the elevation of teachers, who shall have adopted instruction as their regular profession." Here is a "Young Men's Mercantile Library Association," of a like description to those mercantile library asso-

### The Author

● Dr. Jordan, Minneapolis, Minn., is associate professor of history at the University of Minnesota.

ciations, which have been productive of such incalculable benefits to young men in some of our larger eastern cities, and in Europe. The town is not deficient in humane, moral and charitable institutions—I cannot enumerate them all—but will mention only the "Eye Infirmary," the "American Sunday School Union;" the "Young Men's Temperance Society;" the "Hibernian Society" and the "House of Employment of the Female Poor."

The system of common school education, adopted and acted on, in this city, is worthy of the highest commendation, and ought to be imitated in every section of the country. The town is divided into wards, in which there were, last year, 5550 children, between the ages of six and sixteen, and only those, between these ages, are admitted into the public schools. Of these, about 3300 were proceeding through their regular course of instruction and discipline in these admirable seminaries. The whole number of public school edifices, decreed to be built, have not yet been erected. The actual number is eight or nine, and they are capacious and ornamental—well finished and well furnished. The schools, at present organized, occupy thirty commodious apartments, all alike in size, being each thirty-eight feet long and twenty-six feet wide. In these rooms, forty-three teachers, of different grades, and of both sexes are constantly employed. The aggregate amount of their salaries is \$14,000. The male principals are allowed



\$500 a year, and their assistants \$300. The female principals have \$250 and their assistants \$200. The annual expense of educating each pupil is about eight dollars. These institutions have a board of "Trustees and Visitors," for their regulation and management. There is, also, a board of "Examiners and Inspectors," in which are to be found some of the most learned and most respectable of the citizens—men, who are qualified to examine the teachers, as well as their pupils. The Trustees hold meetings for the transaction of business, weekly; the Examiners, monthly. Once a year, a report of the condition of the schools is prepared, and presented to the city authorities and to the public.

Here, you perceive, the ordering and supervision of the education of the youth are regarded as a duty—and a momentous one it is—of the government. It was so regarded in ancient Greece, and from this circumstance half of her glory sprang. I admire the system adopted by the Cincinnatians. It is the proper mode of training up the rising race. They are liquidating the debt, which the present generation owes to the next, to their country and to God. They are doing what they can, to furnish the future stage with actors, enlightened, patriotic and virtuous—actors, who will play well their parts, when their fathers shall have gone down to their dark resting places in the cold tomb. But enough for to-night.

Pearl Street House, June, 13.

I have been honored with calls this morning from Dr. Drake, and President McGuffey, who is a gentleman of highly cultivated intellect, classical in his language, and ardently devoted to the cause of education.\* I have since visited him at the Cincinnati College, where he was patiently employed in

"Teaching the young idea how to shoot."

A small class of twelve or fifteen lads were seated before him, thumbing the leaves of their Virgils, and, occasionally, asking him the meaning of some of the old poet's dark expressions. I must remark, that this college was chartered, and on its feet, in 1819, but was short lived. After continuing its operations six or seven years, it died a natural death. In 1835, successful efforts were made to resuscitate it. The Medical and Law Departments, then added, are in a tolerably prosperous condition. Degrees have been conferred on students in both of these departments.

There is another institution here, at which the disciples of AEsculapius congregate in greater

numbers. It is styled the "Medical College of Ohio." It owns and occupies a capacious building has a library of 1700 well chosen volumes, a large chemical apparatus, and a good collection of anatomical preparations. The class of students, graduated last year, contained 127. This college has given to itself additional value, since the author was there, by numbering among its worthy professors, one of the best men in New England, and one of her most distinguished medical professors—Reuben D. Mussey, M.D., late professor of anatomy and surgery in Dartmouth college, in New Hampshire, and president of the Medical Society of that State.

Do you know, that there exists a marked and striking difference between the inhabitants of the city of New York, and those of every other city on our Atlantic coast? I have observed it, and so have hundreds of others. In Philadelphia, in Boston, in Baltimore, you see the people walk deliberately, converse deliberately, transact business deliberately. You have seen the same in London, in Geneva, in Paris. But not so in the city of Gotham. There, everybody is in a hurry. The people do not *walk*—they *run*—as if escaping from the grasp of the sheriff. All their transactions are performed in haste. They make their fortunes, or lose them, *galloping*. The next time you pass through Wall street, in business hours, look at the jostling, racing multitude, and tell me, if what I have stated, is not the truth. The same sort of hurrying—the same headlong action—is seen, wherever I have yet travelled in these occidental regions. Everything is done with celerity—eating, walking, working—all is effectuated on the high pressure principle.

I will relate an incident by way of illustration. At the large hotels, which have, often, from fifty to an hundred boarders, the instant the bell rings, there is a rush of the multitude, like that of mighty waters, towards the table, and, if an unlucky wight happens through age, or disease, or laziness—the worst of diseases—to be a moment too late, ten chances to one, he loses his seat, if not his meal. A little delay, in my chamber this morning, made me tardy. On entering the eating apartment, and looking eagerly around the immense table, I found that there was not an inch of space left, where a poor, hungry expectant could wedge himself in. Fortunately for me, the evil was not without remedy. I posted off to the bar-keeper, and stated my case to him. He apologized, and immediately conducted me into a private room, where were seated, around a table, a small party of genteel people, partaking of their morning repast. Here, I had room enough, better company, and a very good breakfast. This custom of rushing to the table, like a hundred hawks, pouncing on their prey, I cannot commend, whether it exists in the newer sections of the country, or in the older. It fre-

\*This gentleman, I understand, is now President of the Ohio University, at Athens. The Corporation of that Seminary, could not, in my opinion, have selected a better man to fill the station, vacated by the venerable Dr. Wilson.



quently brings the stranger into a very awkward predicament.

I can almost hear you say, "You appear to be charmed with Cincinnati; and why do you not send me a topographical description of the city?" I cannot do it. The attempt would fail. You would have nothing but a caricature, instead of a true picture. Besides, the place has too many beauties to be told in a single letter. To know, and rightly appreciate them, you must be present. I could tamely say, that it is situated on the north bank of the Ohio river, on two horizontal plains, of about four miles in area—the one raised fifty or sixty feet above the other—plains generated by the waters of the river, at eras, in the earth's history, far remote from each other; that the rough grounds, connecting these plains, are finely graded and built upon: that the lands back of the town are thrown into an infinite variety of forms—hills, dales, and extensive plains, representing a landscape, as picturesque as the most fruitful imagination could paint, spread over, in part, with rural cottages, elegant villas, and splendid gardens, and, in part, covered with native forest trees, decorated with foliage remarkable for its richness and diversity.

I could tell you, that, half a century ago, this was the home of wolves, and bears, and wild-cats—that it now contains a population of more than forty thousand souls, and is, in point of numbers, the sixth city in the Union. The first log cabin was erected in 1789, and, in the winter of the same year, the town was laid out, in the midst of a dark, dense wilderness, and the course of its streets marked on the trees. It was first called Losantiville, and afterwards changed to Cincinnati, by Arthur St. Clair, Governor of the then Territory. It now comprehends within its precincts, forty-five physicians, thirty-seven clergymen, and about an equal number of lawyers. It sends forth four newspapers, daily, one semi-weekly, and eight weekly. It has five banks, with an aggregate capital of \$5,600,000, besides several savings institutions, and fire insurance companies. It is the seat of important commercial and manufacturing operations. It is believed to be the largest pork market on the continent.

Perhaps I might give you a juster idea of the appearance of Cincinnati, by *comparison*. You cannot have forgotten how Genoa appeared to us, as seen from the point, where our steamboat anchored, or from that where the American ship of war, the Potomac, was stationed, farther out in the bay. The view was enrapturing. Our eyes were riveted to it. We had never seen its parallel. Rightly do the Italians, thought we, style Genoa *La Superba*. Here, we could not help imagining, Vespasian took from nature the model of the Colosseum, which he commenced at Rome. The arena of *his*, often saturated with human blood, uselessly, wickedly shed, represents

this narrow, flat plain, overspread with marble houses, and palaces, and churches, and all the pomp and bustle of a populous and magnificent town. The sloping galleries of the Roman Colosseum are a miniature representation of the lofty and ragged Appennine, which forms the semi-circular back grounds of the city, and on which are perched many a sumptuous mansion, many a terraced garden, many an humble cottage, and many a moss-clad ruin.

Were you here, I would conduct you across the Ohio river in the convenient steam ferry-boat, lead you to a spot, half a mile from the water's edge, and there ask you to take a deliberate survey of Cincinnati, and of the country back of it. You would, I think, at once say, that it bears no slight resemblance to the native city of Columbus. The high lands, here, though in some degree similar, are less lofty, less rocky, and exhibit fewer human habitations; but they are far richer, their forms vastly more variegated, and more beautiful. You do not, it is true, here see any thing like the towering light-house of Genoa, or the Cathedral of Lorenzo, or the "palazzo ducale;" nor are you to expect it. Consider the difference in the ages of the two cities. The one is an infant at the breast. The other wears bleached locks. The one is not yet fifty years old. The other is two thousand. But old as she is, her population does not exceed 85,000. That of Cincinnati has already attained to near half of that number; and what will it be, two thousand years hence, if it continues to increase, as it has done, during the last quarter of a century? Let fancy stretch away into futurity and view her then. She will see a little world of men—not a New York—not a Glasgow—but a London. Since the year 1812, her population has received an augmentation of more than 26,000 souls. Should she continue to increase in the same ratio, for two thousand years to come, what will be her numbers? What hill will not then be covered with houses? What valley will not be crowded with them?

### Any Physician May Exhibit Film

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the-public 16-mm. sound film, "When Bobby Goes to School", may be exhibited to the public by any licensed physician in the United States. All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville, Indiana. Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.



## Coverage and Indemnities Which Will Be Offered By Ohio Medical Indemnity, Inc.; License Obtained; Enrollment of Subscribers To Start Soon

OHIO MEDICAL INDEMNITY, INC., which has been organized by the medical profession of Ohio through the initiative of the Ohio State Medical Association to provide cash indemnities against medical, surgical and obstetrical expenses, was issued a certificate of authority to transact business in Ohio by State Superintendent of Insurance Walter Dressel on November 8.

As soon as final arrangements have been completed with the Blue Cross Hospital Service Associations in Cincinnati, Columbus, Akron, Toledo, Youngstown, Canton, Lima and Portsmouth for the handling of administrative details, the company will be ready to enroll subscribers.

Ohio Medical Indemnity, Inc., expects to start the enrollment of subscribers in the 14-county area covered by Hospital Care Corporation of Cincinnati where approximately 500,000 persons are now subscribers to prepaid hospital care coverage. The counties in this area are: Hamilton, Clermont, Brown, Adams, Highland, Clinton, Warren, Butler, Preble, Montgomery, Greene, Clark, Miami and Darke. Activities of the company will be extended to other parts of the state as rapidly as it is possible for the company to do so.

The home office of the company is located at 1328 Huntington National Bank Building, Columbus, with Mr. Charles H. Coghlan, executive vice-president, in charge. General agents will be appointed by Ohio Medical Indemnity, Inc., to handle the enrollment of subscribers in cooperation with the various Blue Cross Hospital Service Association offices.

Stock certificates will be mailed soon to the approximately 600 physicians who purchased the 2,000 shares of preferred stock issued by the company.

Following is a detailed analysis of the terms and provisions of the indemnity contract which will be issued by Ohio Medical Indemnity, Inc., to persons who are members of a group, the monthly premium for a single individual being 60 cents and the monthly premium for a family being \$1.90.

### **Coverage for Various Members of Family Is Provided**

Under the first article of the contract, definitions of the terms "applicant", "family" and "subscriber" are set forth. "Applicant" means the person who signed the application accepted by Ohio Medical Indemnity, Inc., which is referred to throughout the contract as "Ohio Medical". The term "family" means and consists of the applicant, applicant's spouse and the unmarried children over 90 days of age and under 19 years of age of either the applicant or applicant's spouse. "Subscriber" is defined as the applicant and each of the other members of his family, if any, listed on the application. It is provided that any subscriber other than applicant and spouse shall cease to be a subscriber on the attainment of the age of 19 years or the marriage of such subscriber, whichever shall first occur.

### **How Contract Differs From Many Others Offered**

It should be noted that the contract which will be offered by Ohio Medical Indemnity, Inc., differs from contracts offered by many insurance companies in that it provides coverage not only for an individual but also for members of his family under 19 years of age if he desires to subscribe for the family-coverage contract.

### **Standards for Hospital Are Listed in Definition**

Inasmuch as most of the procedures covered by the indemnity schedule will be performed in a hospital, Ohio Medical has found it advisable to establish standards which must be met by an institution in which the services are rendered. As defined by the contract a hospital means an institution established and

maintained for the medical or surgical care of bed patients for a continuous period longer than 24 hours, open to the general public 24 hours each day for emergency care, having a minimum of 20 patient beds, having an average of 3,000 patient days per year, and having on duty 24 hours each day at least one registered nurse.

### **Services, Procedures for Which Indemnity Will Be Paid**

Since the contract provides for surgical expense indemnity the definition of "surgical services" is of primary importance. Following is the definition of that term stated in the contract: "Surgical Services" means the following services rendered by duly licensed physicians and surgeons: (a) Operative and cutting procedures listed in the "Schedule of Indemnities" when performed in a hospital as hereinbefore defined; (b) The treatment of fractures listed in the "Schedule of Indemnities", whether such treatment be rendered in a hospital or elsewhere; (c) The removal of tonsils or adenoids, whether performed in a hospital or elsewhere, but not until after the person undergoing such operation has been a subscriber for at least six consecutive months; (d) Obstetrical services rendered to applicant or applicant's wife, either in a hospital or elsewhere, provided that applicant is the holder of a "Type B Contract", which has been in force for nine consecutive months, but such nine-month waiting period shall not apply to the termination of a pregnancy by miscarriage or the termination of an ectopic pregnancy if, in any such case, the normal date of childbirth would have occurred after such nine-month waiting period.

### **Two Types of Contracts Will Be Offered at the Beginning**

Two types of contracts will be provided by Ohio Medical to start with, but additional types may be offered at a later date. "TYPE A CONTRACT" provides indemnity for certain expenses incurred for Surgical Services, as hereinbefore defined, rendered to applicant only. (Type A Contract provides no indemnity for obstetrical services.) "TYPE B CONTRACT" provides indemnity for certain expenses incurred for Surgical Services, as hereinbefore defined, rendered to applicant and such other members of his family as are listed on the application. (Subject to certain conditions which have been outlined, Type B Contract provides certain indemnity for obstetrical services rendered to applicant or applicant's wife.)

### **Maximum Payments and Payments for Multiple Procedures**

If surgical services as defined in the contract, and explained above, are rendered to a subscriber, Ohio Medical will pay to the applicant the amount shown in the Schedule of Indemnities which is a part of the contract. The indemnities are listed later in this article. Certain regulations governing payments for two or more operations or procedures, for the same or closely interrelated conditions, and for two or more wholly distinct or unrelated procedures have been established. As set forth in the contract, these regulations are:

### **Regulations on Payments for Interrelated Conditions**

If, in connection with any one disease, illness, injury, or other disability, two or more operations or procedures falling within the term "Surgical Services" are performed at one time, or at different times within any one six-month period beginning with the effective date of the contract, on account of the same or closely interrelated conditions, the total amount payable hereunder by Ohio Medical to applicant for such operations or procedures shall be limited to the maximum amount payable under the Schedule of Indemnities for one such operation or procedure. In the case of operations or procedures having a different maximum, such limit shall be the greater.

### **Payment for Distinct and Unrelated Operations**

If two or more wholly distinct and unrelated operations or procedures falling within the term "Surgical Services" are performed during any one disease, illness, injury, or other disability, the amount payable hereunder by Ohio Medical to applicant shall be the sum total payable under the Schedule of Indemnities for each



such operation or procedure, but in no event shall the total amount payable hereunder for all operations and procedures performed during any one disease, illness, injury, or other disability and within any one six-month period beginning with the effective date of the contract, exceed the sum of \$150.

### **Exclusions; Procedures for Which Indemnity Will Not Be Paid**

Ohio Medical Indemnity, Inc., has found it necessary to enumerate certain exclusions, i.e., to provide that indemnity will not be

paid for certain procedures or under certain conditions, although an effort has been made by the company to keep the exclusions at an absolute minimum. Surgical expense indemnity will not be provided by the contract for any of the following: (a) Surgical services (except fractures, tonsillectomies, adenoidectomies, and obstetrics) performed elsewhere than in a hospital; (b) Tonsillectomies and adenoidectomies performed upon a person who has not been a subscriber for at least six consecutive months; (c) Obstetrical services in case applicant has not been the holder of a Type B Contract for nine consecutive months immediately preceding the rendition of such services, or in case the person to whom such obstetrical services are rendered is neither the applicant nor applicant's wife; (d) X-ray and anesthesia services, unless specifically provided for in a rider and for which a specific additional charge is made; (e) Plastic operations for cosmetic or beautifying purposes; (f) Surgical services which are furnished or made available to the subscriber, or for which the cost is payable, under any state or Federal workmen's compensation law, occupational disease law or similar legislation; (g) Surgical services actually furnished to the subscriber, or for which the cost is payable by the United States of America or any governmental agency thereof, or by any state or political subdivision thereof; (h) Surgical services performed in a Veterans Administration hospital, or rendered to a subscriber while he is in the active military service of this or any other country; (i) Hospital, dental, or nursing services, medicines, drugs, appliances, materials, or supplies.

### **Special Coverage for Anesthesia and X-ray Contemplated Later**

Attention is called to the reference to a "rider" providing indemnities for X-ray and anesthesia services. As soon as feasible, Ohio

Medical will provide coverage for X-ray and anesthesia services, at additional cost to the applicant, in those areas where subscribers are not provided with coverage for such services under Blue Cross hospitalization contracts or in event such coverage is discontinued by Blue Cross organizations.

### **How Claims Will Be Handled and Forms Which Will Be Used**

Regulations for the filing and handling of claims and proof of services rendered, etc., are enumerated in the contract. An effort

has been made to keep paper work at a minimum, especially the paper work required of the attending physician. Written notice that Surgical Services have been rendered to a subscriber, with particulars sufficient to identify such subscriber and his physician and surgeon, and setting forth the nature of the Surgical Services performed and the time and place thereof, must be given by or on behalf of applicant to Ohio Medical at its home office in Columbus, Ohio, or to an authorized agent of Ohio Medical, within ten days after the performance of such services.

### **Written Proof of Services Performed To Be Required**

Written proof of the nature and extent of the Surgical Services performed must be furnished to Ohio Medical, at its home office, or to an authorized agent

of Ohio Medical, within 60 days after the performance of the Surgical Services. Such proof shall be upon forms furnished by Ohio Medical and shall be signed by the applicant or applicant's spouse, or by some other person acceptable to Ohio Medical, and shall be signed also by the physician and surgeon performing such services; but if Ohio Medical does not furnish the forms for such proof within 15 days after the receipt of the notice required of the applicant, the requirements of the contract as to such proof shall be deemed to have been complied with by the furnishing, within the

required time for filing proof, of written proof covering the occurrence, character and extent of the Surgical Services on account of which claim is made.

Failure to give notice or to furnish proof within the time limitations set forth above shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice or proof, as the case may be, and that such notice of proof was given as soon as was reasonably possible.

**Authority To Examine Data  
To Be Given To Company**

As a condition precedent to the issuance of a contract, applicant and each other subscriber agree that any physician, surgeon, nurse, or hospital having rendered services to any subscriber, or in possession of any information or records relating thereto, is authorized and directed to furnish to Ohio Medical, at any time, upon request, any and all such information and records, or copies of records.

No action at law or in equity shall be brought against Ohio Medical prior to the expiration of 60 days after written proof has been filed with Ohio Medical as required, nor shall such action be brought at all unless commenced within two years from the date when the Surgical Services forming the basis for such action were rendered.

**Charges for Contracts and  
Methods of Payment**

The amount of the charges for a contract, and the time and the manner of payment, will be specified in the application or in any notice given by Ohio Medical. As has been stated, the monthly charge for a "Type A Contract" (single person) will be 60 cents and the monthly charge for a "Type B Contract" (family) will be \$1.90. All charges will be due and payable monthly, in advance, or as may be otherwise determined by the company. In the event of an increase in the charges, the applicant will be given notice thereof at least 30 days prior to the date when the increase will become effective. It is provided, however, that such notice need not be given if a contract is changed at the request of the applicant.

**How Notice Shall Be Given  
By Company and Applicant**

The contract provides that any notice given by Ohio Medical shall be sufficient if mailed to the applicant at the address appearing on the records of the company, or if posted on the bulletin board of the employer of the group with which the applicant is connected at the time of such notice, or if published once in a newspaper of general circulation in the county of applicant's residence. Also, it is provided that any notice given by the applicant shall be sufficient if mailed to Ohio Medical at its principal office.

**Rules for Changes in Contract by  
Company or by Applicant**

Provisions for changes in a contract are specified. If at any time applicant desires to increase or decrease the number of subscribers, he shall file with Ohio Medical a supplemental application, in writing, listing the desired subscribers. Any such change in the contract shall become effective only in accordance with the rules and regulations adopted by Ohio Medical. The amount of the charge for such increased or decreased coverage, and the time and manner of payment thereof, shall be as described in the paragraph on changes for contract.

**How Subscriber Who Changes  
Job Can Retain Contract**

If, by reason of the termination of employment of applicant or other cause, and while the contract is in force, applicant shall cease to be connected with the group through which his application was received, applicant shall have the right to keep the contract in force by notifying Ohio Medical within ten days after his connection with such group has ceased of his intention to keep the contract in force and by paying to Ohio Medical any unpaid charges then due and, in addition commencing to pay all subsequent charges in such amount and manner and at such times as may be determined by Ohio Medical.



Ohio Medical may change the terms of the contract with respect to charges or indemnity payments or otherwise, but no such change shall become effective unless notice thereof as described above shall be given by Ohio Medical at least 30 days prior to the effective date of such change.

**Conditions Under Which Contract May Be Terminated**

Conditions under which the contract may be terminated are enumerated. Upon default in the payment of the charges required by the contract, the contract shall automatically terminate, without notice, at the expiration of the period for which payment has been made, and a subscriber shall not thereafter be entitled to any further surgical expense indemnity hereunder. The contract may be terminated by applicant or Ohio Medical at any time by giving to the other notice thereof at least 30 days prior to the date when such termination shall become effective; provided, however, that in the event of termination by applicant, such termination shall become effective only at the expiration of the period for which payment has been made.

**Contract Can Be Continued by Surviving Subscribers**

Upon the death of applicant, the contract shall terminate as of the date to which charges have been paid; provided, however, that if the applicant be the holder of a Type B Contract, the surviving subscriber or subscribers shall have the right to continue the contract in force by notifying Ohio Medical within 10 days after the death of applicant of the intention to continue the contract in force and by paying to Ohio Medical any unpaid charges then due and, in addition, commencing to pay all subsequent charges in such amount and manner and at such times as may be determined by Ohio Medical.

**How Applicant May Have His Contract Reinstated**

The contract states how a contract may be reinstated. If this contract shall terminate by reason of default in the payment of charges and the applicant shall desire to reinstate it, he shall file with Ohio Medical a written request for reinstatement accompanied by the amount of the default payments. The contract may then be reinstated upon such terms and conditions as Ohio Medical, in its sole discretion, may determine. In the event Ohio Medical shall reject such request for reinstatement, Ohio Medical shall promptly return to the applicant the amount of the defaulted charges which accompanied such request.

**Provisions Under Which Terms of Contract May Be Waived**

It is provided that no statement by the applicant not included in his application shall avoid the contract or be used in any legal proceedings; and that no agent or representative of Ohio Medical, other than the President, Executive Vice-President or Secretary-Treasurer, is authorized to waive any of the provisions of the contract. Also, it is provided that the contract is personal to the applicant and is not assignable.

**Company Does Not Select Physician for Any Subscriber**

It is specifically stated that Ohio Medical does not select a physician or surgeon for any subscriber, is not responsible for the professional acts, omissions or conduct of any physician or surgeon, and shall be under no liability whatsoever in connection with any care or services rendered by any physician or surgeon other than to provide indemnity to the applicant and the applicant only, for surgical services rendered to a subscriber, and then only to the extent set forth in the contract.

**Schedule of Indemnities Does Not Fix the Doctor's Fee**

The following schedule lists the indemnities payable by Ohio Medical Indemnity, Inc. Special attention is called to the statement prefacing the indemnity schedule to the effect that the amounts listed are not to be understood as fixing or attempting to fix the value of the services of the physician. Also, it should be noted that provision is made in the final paragraph of the schedule of indemnities for the consideration and payment of certain procedures which may not be enumerated in the schedule.

## SCHEDULE OF INDEMNITIES

THE AMOUNTS OF THE INDEMNITIES SHOWN BELOW ARE NOT TO BE UNDERSTOOD AS  
FIXING OR ATTEMPTING TO FIX THE VALUE OF THE SERVICES OF THE PHYSICIAN  
OR SURGEON.

|                                                                                                          | Maximum<br>Indemnity |
|----------------------------------------------------------------------------------------------------------|----------------------|
| <b>Abdomen</b>                                                                                           |                      |
| Appendectomy .....                                                                                       | \$100.00             |
| Gall Bladder removal .....                                                                               | 125.00               |
| Gall Bladder drainage .....                                                                              | 100.00               |
| Gastrectomy .....                                                                                        | 150.00               |
| Bowel resection .....                                                                                    | 150.00               |
| Other cutting into abdominal cavity for diagnosis or treatment, unless other-<br>wise specified .....    | 100.00               |
| <b>Abscess</b>                                                                                           |                      |
| Deep cellulitis drainage .....                                                                           | 10.00                |
| Carbuncle, excision of .....                                                                             | 25.00                |
| Deep breast abscess (boils excepted) .....                                                               | 20.00                |
| <b>Amputations</b>                                                                                       |                      |
| Thigh through hip joint or neck of femur; arm through shoulder joint .....                               | 100.00               |
| Thigh, leg, arm through neck of humerus; forearm through elbow joint; foot<br>through ankle joint .....  | 75.00                |
| Kneecap; foot below ankle; upper arm; forearm .....                                                      | 50.00                |
| Hand at wrist .....                                                                                      | 50.00                |
| Finger or toe .....                                                                                      | 15.00                |
| Fingers or toes (two or more) .....                                                                      | 30.00                |
| Coccyx .....                                                                                             | 35.00                |
| <b>Breast</b>                                                                                            |                      |
| Simple Amputation (single) .....                                                                         | 50.00                |
| Simple Amputation (bilateral) .....                                                                      | 75.00                |
| Radical Amputation (single) .....                                                                        | 100.00               |
| Radical Amputation (bilateral) .....                                                                     | 150.00               |
| Tumor (non-cancerous) .....                                                                              | 25.00                |
| <b>Chest</b>                                                                                             |                      |
| Complete thoracoplasty .....                                                                             | 150.00               |
| Lobectomy or pneumonectomy .....                                                                         | 150.00               |
| Cutting into thoracic cavity for diagnosis or treatment .....                                            | 50.00                |
| Pneumothorax, induced:                                                                                   |                      |
| First induction .....                                                                                    | 10.00                |
| Each refill (maximum of five) .....                                                                      | 5.00                 |
| Cutting into trachea .....                                                                               | 35.00                |
| Bronchoscopy, including biopsy, removal of foreign body, or treatment .....                              | 35.00                |
| Each subsequent operation (maximum of three) .....                                                       | 10.00                |
| <b>Dislocations</b>                                                                                      |                      |
| For an open reduction of dislocation, unless otherwise specified, indemnity increased<br>by 50 per cent. |                      |
| Shoulder (closed) .....                                                                                  | 30.00                |
| Shoulder (open) .....                                                                                    | 75.00                |
| Heel (closed) .....                                                                                      | 25.00                |
| Heel (open) .....                                                                                        | 75.00                |
| Hip joint .....                                                                                          | 50.00                |
| Knee .....                                                                                               | 35.00                |
| Kneecap .....                                                                                            | 15.00                |
| Ankle .....                                                                                              | 30.00                |
| Elbow (closed) .....                                                                                     | 30.00                |
| Elbow (open) .....                                                                                       | 60.00                |



|                                                                                                                                                                                                                                                                                                                                     | Maximum<br>Indemnity |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| Collar bone; wrist.....                                                                                                                                                                                                                                                                                                             | 25.00                |
| Jaw.....                                                                                                                                                                                                                                                                                                                            | 15.00                |
| Finger or toe.....                                                                                                                                                                                                                                                                                                                  | 5.00                 |
| <b>Ear, Nose, or Throat</b>                                                                                                                                                                                                                                                                                                         |                      |
| Mastoidectomy:                                                                                                                                                                                                                                                                                                                      |                      |
| One side.....                                                                                                                                                                                                                                                                                                                       | 75.00                |
| Both sides.....                                                                                                                                                                                                                                                                                                                     | 100.00               |
| Tonsillectomy and adenoidectomy:                                                                                                                                                                                                                                                                                                    |                      |
| Subscriber under age 12.....                                                                                                                                                                                                                                                                                                        | 25.00                |
| Subscriber of age 12 or over.....                                                                                                                                                                                                                                                                                                   | 35.00                |
| Sinus operations:                                                                                                                                                                                                                                                                                                                   |                      |
| Frontal, intranasal, simple.....                                                                                                                                                                                                                                                                                                    | 35.00                |
| Frontal, external.....                                                                                                                                                                                                                                                                                                              | 50.00                |
| Puncture for drainage or irrigation.....                                                                                                                                                                                                                                                                                            | 10.00                |
| Antrum, radical.....                                                                                                                                                                                                                                                                                                                | 40.00                |
| Submucous resection of nasal septum.....                                                                                                                                                                                                                                                                                            | 35.00                |
| <b>Excision or Fixation by Cutting</b>                                                                                                                                                                                                                                                                                              |                      |
| Hip or shoulder joint.....                                                                                                                                                                                                                                                                                                          | 100.00               |
| Joints of elbow, wrist or ankle.....                                                                                                                                                                                                                                                                                                | 50.00                |
| Knee joint.....                                                                                                                                                                                                                                                                                                                     | 75.00                |
| Removal of semilunar cartilage of knee.....                                                                                                                                                                                                                                                                                         | 75.00                |
| <b>Eye</b>                                                                                                                                                                                                                                                                                                                          |                      |
| Removal of cataract.....                                                                                                                                                                                                                                                                                                            | 75.00                |
| Needling of cataract.....                                                                                                                                                                                                                                                                                                           | 35.00                |
| Removal of lacrimal sac.....                                                                                                                                                                                                                                                                                                        | 35.00                |
| Any cutting operation into the eyeball (through cornea or sclera).....                                                                                                                                                                                                                                                              | 50.00                |
| Removal of eyeball.....                                                                                                                                                                                                                                                                                                             | 50.00                |
| Cutting on extrinsic eye muscles.....                                                                                                                                                                                                                                                                                               | 35.00                |
| Other cutting operation on eyeball or eye muscles.....                                                                                                                                                                                                                                                                              | 20.00                |
| <b>Fractures</b>                                                                                                                                                                                                                                                                                                                    |                      |
| The amounts shown below are for simple fractures—single or multiple. For compound fracture, the maximum amount of reimbursement will be one and one-half times the corresponding amount shown below. For fracture requiring open operation, the maximum amount of reimbursement will be twice the corresponding amount shown below. |                      |
| Thigh.....                                                                                                                                                                                                                                                                                                                          | 75.00                |
| Leg, kneecap, upper arm, vertebra, or vertebrae, or pelvis (coccyx and vertebral processes excepted).....                                                                                                                                                                                                                           | 50.00                |
| Lower jaw (alveolar processes excepted) collar bone, shoulder blade.....                                                                                                                                                                                                                                                            | 25.00                |
| Forearm:                                                                                                                                                                                                                                                                                                                            |                      |
| Shaft one bone.....                                                                                                                                                                                                                                                                                                                 | 25.00                |
| Shaft both bones.....                                                                                                                                                                                                                                                                                                               | 35.00                |
| Wrist or ankle.....                                                                                                                                                                                                                                                                                                                 | 25.00                |
| Hand or foot.....                                                                                                                                                                                                                                                                                                                   | 15.00                |
| Finger or toe.....                                                                                                                                                                                                                                                                                                                  | 10.00                |
| Each additional finger or toe.....                                                                                                                                                                                                                                                                                                  | 5.00                 |
| Nose.....                                                                                                                                                                                                                                                                                                                           | 10.00                |
| Rib.....                                                                                                                                                                                                                                                                                                                            | 10.00                |
| Multiple ribs.....                                                                                                                                                                                                                                                                                                                  | 20.00                |
| Skull:                                                                                                                                                                                                                                                                                                                              |                      |
| Open operation within dura mater.....                                                                                                                                                                                                                                                                                               | 150.00               |
| Open operation not within dura mater.....                                                                                                                                                                                                                                                                                           | 75.00                |
| <b>Genito-Urinary Tract</b>                                                                                                                                                                                                                                                                                                         |                      |
| Removal of entire kidney.....                                                                                                                                                                                                                                                                                                       | 150.00               |
| Removal of entire prostate.....                                                                                                                                                                                                                                                                                                     | 150.00               |

|                                                                                                                      | Maximum<br>Indemnity |
|----------------------------------------------------------------------------------------------------------------------|----------------------|
| Removal of part of prostate:                                                                                         |                      |
| By endoscopic means.....                                                                                             | 50.00                |
| By other cutting operation.....                                                                                      | 75.00                |
| Removal of uterus.....                                                                                               | 150.00               |
| Other cutting operations with abdominal approach upon uterus, or for removal<br>of uterine appendages or tumors..... | 100.00               |
| Cutting into bladder and removal of tumors.....                                                                      | 100.00               |
| Other cutting into bladder.....                                                                                      | 75.00                |
| Cuting into kidney, including removal of stones or tumors.....                                                       | 100.00               |
| Fixation of kidney.....                                                                                              | 100.00               |
| Cutting into ureter.....                                                                                             | 100.00               |
| Cystoscopic Examination.....                                                                                         | 10.00                |
| Cystoscopy for removal of urinary stones or bladder tumor:                                                           |                      |
| First operation.....                                                                                                 | 25.00                |
| Each subsequent operation.....                                                                                       | 10.00                |
| Varicocele.....                                                                                                      | 25.00                |
| Hydrocele with excision of tunica vaginalis.....                                                                     | 35.00                |
| Orchidectomy.....                                                                                                    | 50.00                |
| Epididymectomy.....                                                                                                  | 50.00                |
| Dilatation and curettage (non-puerperal).....                                                                        | 25.00                |
| Circumcision (only to subscribers 12 years of age or older).....                                                     | 15.00                |
| <b>Goiter</b>                                                                                                        |                      |
| Thyroidectomy—complete procedure, including ligation of thyroid arteries, to<br>be treated as an operation.....      | 150.00               |
| <b>Hernia, Cutting Operation</b>                                                                                     |                      |
| Single hernia.....                                                                                                   | 75.00                |
| More than one hernia.....                                                                                            | 100.00               |
| <b>Rectum</b>                                                                                                        |                      |
| Hemorrhoidectomy:                                                                                                    |                      |
| Internal, or internal and external.....                                                                              | 50.00                |
| External only.....                                                                                                   | 25.00                |
| Fistula, resection of:                                                                                               |                      |
| Single.....                                                                                                          | 35.00                |
| Multiple.....                                                                                                        | 50.00                |
| Abdominal perineal resection.....                                                                                    | 150.00               |
| <b>Tendons, Suture of</b>                                                                                            |                      |
| Single tendon.....                                                                                                   | 25.00                |
| Each additional tendon (maximum payment of \$50.00).....                                                             | 10.00                |
| <b>Tumors, Cysts, Etc., Removal of</b>                                                                               |                      |
| Non-malignant skin tumor or subcutaneous lipoms:                                                                     |                      |
| Single.....                                                                                                          | 10.00                |
| Multiple.....                                                                                                        | 20.00                |
| Malignant tumors of face, lip, or skin:                                                                              |                      |
| Simple excision.....                                                                                                 | 25.00                |
| Radical excision.....                                                                                                | 40.00                |
| Pilonidal sinus or cyst.....                                                                                         | 50.00                |
| <b>Varicose Veins</b>                                                                                                |                      |
| Saphenous vein, ligation with injection of involved tributary branches:                                              |                      |
| Unilateral.....                                                                                                      | 40.00                |
| Bilateral.....                                                                                                       | 50.00                |
| <b>*Maternity Cases</b>                                                                                              |                      |
| Obstetric delivery.....                                                                                              | 50.00                |
| Caesarean section.....                                                                                               | 100.00               |
| Abdominal operation for ectopic pregnancy.....                                                                       | 100.00               |



|                                                               | Maximum<br>Indemnity |
|---------------------------------------------------------------|----------------------|
| Miscarriage (abortion), including dilation and curettage..... | 25.00                |
| Miscarriage (spontaneous) .....                               | 15.00                |

\*Benefits are available only if Applicant is the holder of a Type B Contract, and then only under the specific conditions and limitations prescribed.

FOR ANY CUTTING OPERATION OR FRACTURE NOT ENUMERATED IN THE FOREGOING SCHEDULE OF INDEMNITIES, OHIO MEDICAL WILL DETERMINE THE AMOUNT OF INDEMNITY, IF ANY, TO BE PAID.

## Officers and Directors

Officers of Ohio Medical Indemnity, Inc., are: Dr. L. H. Schriver, Cincinnati, president; Mr. James E. Stuart, Cincinnati, and Mr. Ralph W. Jordan, Columbus, vice presidents; Mr. Charles H. Coghlan, Columbus, executive vice president; Mr. Charles S. Nelson, Columbus, secretary-treasurer. Mr. Wayne E. Stichter, Toledo, is serving as general counsel.

Members of the Board of Directors are: Dr. Schriver, Dr. Robert C. Rothenberg, Cincinnati; Dr. R. K. Finley, Dayton; Dr. Carl S. Mundy, Toledo; Dr. Edgar P. McNamee, Cleveland; Dr. William M. Skipp, Youngstown; Dr. C. C. Sherburne, Columbus; Dr. Jonathan Forman, Columbus; Dr. Carl R. Steinke, Akron; Dr. J. Craig Bowman, Upper Sandusky; Dr. Carl A. Lincke, Carrollton; Dr. Barney J. Hein, Toledo; Dr. Charles L. Ferguson, Portsmouth; Mr. Harold Vincent, Akron; Judge Henry Harter, Canton; Mr. L. F. Reinartz, Middletown; Mr. C. H. Neville, Lima; Mr. Dave Endres, Youngstown; Mr. E. C. Pohlman, Columbus; The Most Reverend Karl J. Alter, D.D., Toledo; Mr. Charles H. Mylander, Columbus.

Those serving on the Executive Committee are: Dr. Mundy, chairman; Drs. Rothenberg, Sherburne, Skipp, Finley and McNamee; Mr. Pohlman and Bishop Alter. The president, executive vice president and secretary-treasurer are ex-officio members of the committee.

## Gifts Made to Medical School

Western Reserve University has received two checks from the Beaumont Foundation, through Nathan L. Dauby, Morton J. May and Nathan Loeser, Trustees, for \$200,000 and \$20,000, respectively.

One-half of the larger gift has been designated to be applied toward the cost of a new building to be constructed by the School of Applied Social Science, at an ultimate outlay by Western Reserve University of approximately \$500,000. The remainder of the larger gift will be devoted toward research work in the Department of Pathology of Western Reserve University. The gift of \$20,000 will be applied to help finance a project to be undertaken jointly by Western Reserve University and the Cleveland Hearing and Speech Center, a portion thereof to be used for completing the remodeling of the new headquarters of the Center at Euclid Avenue and Abington Road, on the Western Reserve campus, and the remainder in research and in training of teachers in speech and hearing work.

## Ohio Prisons High As Blood Donors

Ohio's three prisons for men carried off major honors in donating blood for use by the armed forces and contributed almost 15 per cent of all blood donated through the country by penal inmates, according to a nationwide survey. The Ohio Penitentiary led the country's institutions in blood contributions, with the Mansfield Reformatory ranking fifth and the London Prison Farm ninth among 70 Federal and State prisons which participated in the program. Inmates of these 70 institutions gave 100,695 pints of blood. Of the total, Ohio's state prisons combined donated 14,614 pints, with the Ohio Penitentiary's effort of 6,690 the largest in the country. Mansfield Reformatory and the London Prison Farm contributed 3,960 and 3,401 pints, respectively. Ohio's total included the Women's Reformatory at Marysville, whose inmates gave 563 pints of blood, to rank third in the country among women's prisons. Over 300 Ohio Penitentiary inmates qualified for the American Red Cross Gallon Club by contributing eight or more pints of blood.

# Laudable Changes Made in Hospital Construction Bill; Commission Formed in Ohio To Conduct Surveys

THE U. S. Senate Committee on Education and Labor has reported with approval a revised measure (S. 191) for Federal aid in the construction of hospitals and related facilities. Several important amendments are suggested by the committee.

The reported bill provides for a five-year program and authorizes annual appropriations of \$75,000,000 for each of the five fiscal years, plus unappropriated and unexpended balances, as compared with \$100,000,000 in the original bill for the first year and an unlimited authorization thereafter.

In the original bill an appropriation of \$5,000,000 was authorized for state administrative expenses. The committee has eliminated this authorization, taking the position that the state should be able to handle this feature without Federal aid.

Federal funds to be made available by this legislation will be allotted according to a new formula devised by the committee which eliminates administrative discretion in its application.

## LIMITED TO PUBLIC HEALTH

The term "public health center" was defined in the original bill as a publicly owned facility for the provision of public health services *and medical care*. The reported bill eliminates the italicized words, thus limiting the functions of such centers to the provision of public health services, the scope of which will be determined by state law.

As introduced, the bill required a state plan to embody a hospital construction program which would be in accord with "standards" prescribed by the Surgeon General with the approval of the Federal Advisory Council. The Senate committee concluded that the independence of the states in carrying out their plans will be better preserved if the Congress specifies general requirements and limits the Federal Government's regulatory control to those requirements. These general requirements are set forth specifically in the amended bill. They relate in the main to the number and general manner of distribution of hospitals to be constructed under the program. The scope of the Federal regulatory powers as contemplated by the requirements is entirely consistent, in the opinion of the committee, with effective Federal control of appropriated moneys.

## A.M.A. SUGGESTION APPROVED

During the course of the hearings on the bill, representatives of the American Medical Association suggested the advisability of including a provision, similar to the one contained in the

Lanham act, to make it clear that Federal control could not be exercised over the operation and maintenance of hospitals constructed under the program. Such a proscription is contained in the reported bill. To prevent the transfer of a hospital constructed under the program to a transferee not approved by the state agency, a provision has been added authorizing the United States to recover the Federal percentage of the value of the hospital at the time of the transfer. A similar authority may be exercised if a non-profit hospital ceases to remain in that category.

## OHIO'S PLANNING UNDER WAY

Assuming that the Hill-Burton Bill will ultimately be passed in some form, hospital authorities, physicians and others in Ohio are preparing the groundwork for making use of its provisions in this state.

Through the initiative of the Ohio Hospital Association, Governor Lausche has named a commission on Hospital Care to start a survey of hospital needs in Ohio immediately and later to serve as advisor to the Ohio Department of Health under the provisions of the Hill-Burton Bill.

The commission at its first meeting elected Dr. Roger Heering, State Director of Health, as chairman and Mr. Harry Eader, executive secretary, Ohio Hospital Association, as secretary-treasurer. Arrangements for a survey, financing, etc., were discussed.

## MEMBERS OF COMMISSION

Members of the Ohio Commission on Hospital Care in addition to Dr. Heering and Mr. Eader, are:

Frank F. Tallman, M.D., Ohio Commissioner of Mental Diseases.

Lee S. Lanpher, President, Ohio Hospital Association, and Superintendent of Lutheran Hospital, Cleveland.

Robert M. Porter, Superintendent of Children's Hospital, Columbus.

Guy J. Clark, Executive Secretary, Cleveland Hospital Council.

Wilson L. Benfer, Superintendent of Toledo Hospital, Toledo.

M. F. Steele, M.D., Superintendent of Christ Hospital, Cincinnati.

David A. Tucker, Jr., M.D., Cincinnati.

George A. Woodhouse, M.D., Pleasant Hill.

William S. Konold, General Manager of Doctors Hospital, Columbus.

Charles F. Kettering, Vice-President and Director, General Motors Corp., Trustee, Miami Valley Hospital, Dayton.

Winfred G. Leutner, President, Western Reserve University, Cleveland.

J. T. Wearn, M.D., Dean of the College of Medicine, Western Reserve University, Cleveland.

Joseph W. Fichter, Columbus, Master of Ohio State Grange.

Frederick G. Geier, President of the Cincinnati Milling Machine Company, Cincinnati.

L. J. Greenwald, D.D.S., Columbus.

Miss Celia Cranz, R.N., Member, State Nurses Board of Ohio, and Superintendent of Nurses, Akron City Hospital, Akron.

Charles H. Wesley, Ph.D., President, Wilberforce University, Wilberforce.

Grove Patterson, Editor of *Toledo Blade*, Toledo.

Mrs. Charles W. Hoke, Chairman, Health Committee of the Ohio Federation of Women's Clubs, Sandusky.

A. R. Mangus, Ph.D., Professor of Rural Economics and Rural Sociology, Ohio State University.

Fred Phillips, M.D., Zanesville.

Herbert D. Chamberlain, M.D., McArthur.



# Federal Compulsory Sickness Insurance System Proposed By President Truman in Special Message to Congress

**A** SYSTEM of compulsory sickness insurance under the direction of the Federal Government was proposed to the Congress on November 19 by President Truman.

Complete details of his proposal, referred to as a five-point health program, were not available as this issue of *The Journal* went to press, although Mr. Truman stated that he would have more to say about his proposal in a later message to Congress.

Neither were details available on what are apparently new bills to carry out the President's recommendations, introduced immediately by Messrs. Wagner, Murray and Dingell.

**Additional information on the President's proposal and on the measures which have been introduced putting the question before Congress will be published in later issues of *The Journal* after there has been an opportunity to study and analyze them carefully.**

## TEXT OF A.P. ARTICLE

Following is the text of an article carried on the wires of the Associated Press following the receipt of President Truman's message to Congress:

\* \* \* \*

President Truman proposed to Congress today (Nov. 19) a compulsory "health insurance" system for "all persons who work for a living".

Mr. Truman suggested that the premiums be calculated on the first \$3,600 of a person's yearly earnings, and mentioned 4 per cent of such income in his discussion of premiums. How much should be paid by the public through a direct tax and how much by the government, he left up to Congress.

This is one of five points in a health program that the President outlined in a message urging "careful consideration . . . now". The others:

## FOUR OTHER PROPOSALS

(1) Federal financial aid to states and localities for enlarging, modernizing and building new hospitals and other health facilities.

(2) More generous grants to the states for public health services and maternal and child care.

The sum of \$20,000,000 yearly is now authorized for such purposes.

(3) Federal grants to public and to nonprofit private institutions to promote medical education and research.

(4) Payments of benefits "to replace at least part of the earnings that are lost during the period of sickness and long-term disability".

## WILL GIVE DETAILS LATER

Mr. Truman suggested that the sick benefits could be provided through expansion of the pres-

ent social security system. He said he would detail his plan in a separate message on social security.

Sen. Robert F. Wagner, Democrat, New York, with the co-sponsorship of Sen. James E. Murray, Democrat, Montana, immediately introduced a Senate bill designed to carry out the program. The measure does not provide any particular method for financing the health insurance plan, however. Wagner said that "if the Congress thinks that it is sound" a method could be worked out jointly by Senate and House committees.

At the other end of the Capitol a measure embodying Mr. Truman's plan was offered by Rep. John D. Dingell, Democrat, Michigan.

## WOULD TAX FIRST \$3,600 WAGES

In suggesting \$3,600 as the basis for the health insurance premium, Mr. Truman noted that the first \$3,000 of yearly earnings is the basis on which social security premiums are calculated now. He proposed that social security also be figured on \$3,600. The social security premium now is 2 per cent, of which employer and employee each pays half.

Mr. Truman based his discussion of a 4 per cent assessment for the health insurance on a showing that the American people "have been spending, on the average, nearly this percentage of their income for sickness care".

"But 4 per cent is only an average" at the present time, the President's message said. "It is cold comfort in individual cases. Individual families pay their individual costs, and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income."

## SAYS IT'S NOT "SOCIALIZED MEDICINE"

Twice in his message Mr. Truman emphasized that his insurance plan was "not socialized medicine". Wagner made the same statement to the Senate.

The President said:

"Socialized medicine means that all doctors

work as employees of the government. The American people want no such system. No such system is here proposed."

"Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: Whether or not patients get the services they need would not depend on how much they can afford to pay at the time", Wagner said.

### Two New Division Chiefs Named By Department of Health

Two new division chiefs have joined the staff of the State Department of Health. They are: Dr. P. L. Harris, chief, Division of Communicable Diseases; and Dr. Thomas F. Mancuso, chief, Division of Industrial Hygiene.

Health commissioner of Portage County since 1938, Dr. Harris previously was associated with the State Department of Health as medical inspector in the Bureau of Communicable Diseases, 1935-1937, and as assistant chief of the Bureau of Venereal Disease, 1937-1938. Dr. Harris was in the service during World War I, with B Battery, 134th Field Artillery, 37th Division. His premedical education was obtained at Mt. Union College, Alliance, from which he graduated with the B.S. degree in 1925.

Dr. Harris is a graduate of the Rochester School of Medicine and Dentistry, 1929. His postgraduate training included an internship at Babies' and Children's Hospital, Cleveland, 1929-1930; assistant resident pediatrician at the same hospital, 1930-1931, and resident in pediatrics and communicable diseases at Cleveland City Hospital, 1931-1932. He was a city physician with the Cleveland Health Department, 1932-1935.

An officer of the United States Public Health Service, Dr. Mancuso was chief, Division of Industrial Hygiene, Oregon State Board of Health, 1943-1945, and was industrial hygiene physician in the Division of Industrial Hygiene, Michigan State Department of Health, 1942-1943. He received his premedical training at Columbia University, New York and Creighton University, Omaha, Nebraska, from which he graduated with the B.S.M. degree in 1933. His M.D. degree is from Creighton University School of Medicine, 1937.

Dr. Mancuso was on the house staff at Kings County Hospital, New York, 1937-1942, serving successively as surgical intern, medical intern, resident in pathology and resident in obstetrics and gynecology.

### Rulings of Attorney General of Interest to Physicians

Among the opinions recently issued by Attorney General Hugh S. Jenkins are several of interest to the medical profession. The syllabi follow:

**No. 386**—Sections 3411-1 and 3411-2, G.C., confer no authority upon township trustees and a municipal corporation to enter into an agreement in which the trustees agree to furnish township funds for an addition to a hospital to be erected by the municipality.

**No. 426**—County commissioners may permit the county coroner to use, in the discharge of his official duties, a motor vehicle purchased by them for their own use under Sections 2412-1 and 2412-2, G.C., and also supply gasoline and oil therefor.

**No. 469**—The provisions of Section 2855-33, G.C., enacted by the 96th General Assembly will not be operative to change the compensation of a coroner who is in office at the effective date of said enactment, and he will continue during his then existing term to receive the compensation provided by the law in force when such term began.

**No. 481**—The expense of treatment of an indigent in the hospital for tuberculosis should be paid by the county of legal residence under Sections 3139 to 3139-22, G.C. Hospitalization at county expense of a tubercular person is not poor relief within the meaning of Section 3477, G.C. Physical absence from the county of a person who is serving in the Armed Services of the United States does not toll the running of the twelve-month period for establishing a legal settlement under the provisions of Section 3477, General Code.

**No. 522**—Where an indigent person in a township is found to be suffering from a contagious disease and is in need of hospital care, and hospital facilities for the treatment of the disease from which such person is suffering are not available in the county where such township is located, it is the duty of the township trustees to contract with a hospital outside of the county for such hospital care and to pay for the same in accordance with the terms of Section 3480, G.C.

**No. 544**—Payment for medical, nurse and hospital services and medicines which become necessary as the result of an injury suffered by an employee and which are furnished subsequent to June 29, 1917, should be made in accordance with the provisions of Sec. 1465-89, G. C., as it now reads, regardless of whether the injury to the employee occurred prior or subsequent to said date. (Opinions of the Attorney General, 1917, page 1690, approved and followed.)



# VETERANS' INQUIRY DEPARTMENT

## Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

**T**HIS is the inauguration of *The Journal's* new feature—the Veterans' Inquiry Department—advance notice of which was published in the November issue.

The purpose of the new department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

This new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

### OPPORTUNITIES SOUGHT

**PEDIATRICIAN:** Navy medical officer, aged 33, graduate of Ohio State University College of Medicine, trained in pediatrics, interested in pediatrics practice—preferably with group clinic. V.I.D. No. 1, care of Ohio State Medical Journal.

**GENERAL SURGERY:** Discharged Army medical officer, age 35, graduate of Northwestern University Medical School, surgical residency in approved Ohio hospital, seeking general surgical practice in Ohio or associateship or assistantship with man in practice. V.I.D. No. 2, care of Ohio State Medical Journal.

**OTOLARYNGOLOGY TRAINING:** Training in Otolaryngology through residency or assistantship sought by Army medical officer to be separated from service soon; age 32; graduate of Ohio State University College of Medicine. V.I.D. No. 3, care of Ohio State Medical Journal.

**OBSTETRICAL TRAINING:** Discharged medical officer desires assistantship or short residency in obstetrics and gynecological surgery or general surgery for period of month, six weeks or two months; age 48; graduate of St. Louis University School of Medicine. V.I.D. No. 4, care of Ohio State Medical Journal.

**SURGICAL ASSISTANTSHIP:** Wanted by veteran, age 33; six years surgical training including year of thoracic surgery; four years of Army surgery in states and overseas. Available after January 2. Ohio license. V.I.D. No. 5, care of Ohio State Medical Journal.

**SURGICAL PRACTICE:** Discharged medical officer, age 32, graduate of Ohio State University College of Medicine and residency in surgery University Hospitals, Min-

neapolis; desires surgical practice. V.I.D., No. 6, care of Ohio State Medical Journal.

**EQUIPMENT NEEDED:** Returning medical officer desires to purchase an Ear, Nose and Throat Unit, new, or second hand if in good condition. V.I.D., No. 7, care of Ohio State Medical Journal.

### OPPORTUNITIES OFFERED

**WANTED:** Physician, for \$25,000 practice in town of 3,000 with drawing population of 30,000 in Northeastern Ohio. Practice combined surgery and internal medicine. Modern 15-room clinic building, including 6-bed ward, of deceased physician, with \$5,000 worth of equipment, X-ray, laboratory facilities, instruments, supplies, library and records available at reasonable terms. G.A.T., in care of Ohio State Medical Journal.

**INDUSTRIAL POSITION:** Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

**EQUIPMENT AVAILABLE:** Physician desiring to retire from large general practice will dispose of equipment, complete except an E.C.G. but including X-ray 100 milli., colormeter, electric centrifuge, short wave, etc., to returning veteran. W.S., care of Ohio State Medical Journal.

**INDUSTRIAL COMMISSION:** Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

**PRACTICE AND OFFICE FOR SALE:** Practice in community of 2,000, unopposed; modern six-room recently constructed brick office building for sale or rent. Combined industrial and rural practice. H.B.K., care of Ohio State Medical Journal.

**OFFICE SPACE TO SHARE:** Space available in large city. Within year plan to move to an office in home. Will sublet smaller office rooms; common waiting room and use of space in larger office room except during my office hours. Prefer man in general practice, internist or pediatrician. B.G.S., care of Ohio State Medical Journal.

**PARTNERSHIP:** Good location for young M.D. Will consider partnership, nothing to sell. Five-room apartment above office available for living quarters. Contact Dr. A. B. Martin, Blanchester, Ohio.

**E.N.T. PRACTICE AVAILABLE:** Due to sudden death of Dr. Horace F. Tangeman, Cincinnati otolaryngologist, there is available for purchase his practice and equipment which is extensive and complete. Equipment includes several sets of treatment and surgical instruments of highest quality. Office on Sixth Floor, Union Central Bldg., Cincinnati, ready for immediate occupancy. Communicate with John N. Gatch, attorney for executrix, 1421 Union Central Bldg., Cincinnati.

**EMPLOYMENT OPPORTUNITIES:** For physicians, good salary, institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne School, Fort Wayne 1, Indiana.

**ASSISTANT DIVISION CHIEF:** Position for physician as Assistant Chief, Division of Child Hygiene, Ohio Department of Health, available. Salary \$4,400 to \$4,800. Must be graduate of approved medical school, one year's internship and at least one year's graduate training, plus one year of training or experience in clinical pediatrics.



Experience in maternal and child health desirable. Must be licensed in Ohio or eligible for licensure. Apply, Chief of Division of Child Hygiene, Ohio Department of Health, State Departments Building, Columbus 15.

**STATE HOSPITAL STAFF OPENINGS:** Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

**PUBLIC HEALTH OFFICERS NEEDED:** Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

**AREAS NEEDING PHYSICIANS:** A list of Ohio areas badly in need of physicians, primarily for general practice—communities which were not the residence of any medical officer prior to the war—will be furnished on inquiry by the Headquarters Office, Ohio State Medical Association, Columbus.

**PRACTICE FOR SALE:** Active practice in county seat, Northwestern Ohio, for sale. Average of 100 obstetrical cases a year. Most physicians in upper age group. Railroad and insurance appointments available. Introduction and help for limited time offered. Equipment includes X-ray, diathermy, modern furniture, complete tonsillectomy instruments, large supply of drugs and supplies. Complete records of patients on file. No real estate for sale. Nominal rent. Hospitals nearby. Thriving industries and fine agriculture community, with paved roads. Estimated price, without complete inventory, \$4,000 to \$5,000. Box X, Ohio State Medical Journal.

## New Journal of Hematology

The launching of the publication, *Blood—The Journal of Hematology*, to appear in January, will establish another significant "first" in the annals of the American scientific journalism. Devoted exclusively to the field of the blood and blood-forming organs, the new periodical will serve a branch of medical practice and research that has never till now had an organ of its own in the Western Hemisphere.

Dr. William Dameshek of Boston is editor-in-chief, with Dr. Charles A. Doan, Dean, Ohio State University College of Medicine, Columbus; Dr. Thomas Hale Ham, A. U. S., Edgewood Arsenal, Md.; Dr. Roy R. Kracke, Birmingham, Ala.; Dr. Nathan Rosenthal, New York, and Dr. Maxwell M. Wintrobe, Salt Lake City, as associate editors. Dr. George R. Minot of Boston is consulting editor. An advisory editorial board, which includes Dr. Russell L. Haden, Cleveland, has been named from among ranking specialists. Editorial offices are at 25 Bennet Street, Boston, and business affairs will be in the hands of Grune and Stratton, 381 Fourth Avenue, New York, who will publish the journal. The subscription rate is \$6 per year.

Departments of the magazine will comprise editorials, case reports, book reviews, abstracts of current literature, and notes on news and methods. It will be published bimonthly.

## Workmen's Compensation Claims Analyzed as to Type of Injury

The industrial workers of Ohio still have a penchant for getting their fingers into things, it is disclosed in a statistical study of Ohio's 1944 industrial accident record made by the statistical laboratory of the Division of Safety and Hygiene.

The analysis of the 283,634 injury and occupational disease claims, as regards parts of the body affected by accidents, discloses that 70,437 of them had their origin in injuries to fingers. These included the loss of 1,667 whole fingers and 1,261 parts of fingers.

Eye injuries rated second in accident frequency with 58,755 claims, which included the loss of 134 eyes. The injuries included 21,684 puncture wounds, 15,377 due to foreign body in the eye, 13,617 to lacerations, 4,355 to burns and scalds, 1,072 to contusions and 107 to occupational diseases.

During the year there were 1,414 traumatic amputations, 218 asphyxiations, 16,861 burns and scalds, 53,823 contusions, 656 dislocations, 15,377 foreign body, 18,259 fractures, 85,610 lacerations, 39,470 puncture wounds and 8,249 occupational disease cases.

In addition to the finger and eye injuries mentioned, there were 15,941 to the head and face, 38,963 to the trunk, 29,321 to the arms, 20,251 to the hands, 24,658 to the legs, 13,789 to the feet and 11,519 to the toes.

The 18,259 fractures included 829 to parts of head and face, 5,090 to fingers, 1,538 to legs, 2,028 to parts of the trunk, 1,673 to arms, 681 to hands, 1,655 to feet and 4,765 to toes.

Included in the list of injuries to the trunk were 5,157 hernia cases.—*O. I. C. Monitor*, Sept., 1945.

## Dr. Powell Honored By Colleagues

Public health officials of Northwestern Ohio honored Dr. H. J. Powell, Wood County's health commissioner for over a quarter of a century, with a luncheon at Bowling Green, October 25. Dr. Powell will retire from public health work at the end of this year. Representatives were present from the State Department of Health and many local health departments.

During a business session, the health commissioners revived their district organization for future meetings. The following officers were elected: Dr. Walter H. Hartung, health commissioner of Toledo, president; Dr. S. F. Whisler, Findlay, Hancock County health commissioner, vice-president; and Dr. Thomas W. Mahoney, Toledo, Lucas County health commissioner, secretary. Next meeting of the group will be held in Findlay in January.



# Additional Ohio Physicians Separated From Army, Navy, Or Other Services Since V-E Day; Total Now 452

**F**OLLOWING is a list of 275 additional Ohio physicians who have been separated from the Army, Navy and other wartime services or are on terminal leave, pending official separation, according to information received by the Ohio State Medical Association.

Including the list of names published in the November issue of *The Journal*, this makes a total of 452 Ohio physicians separated, or on terminal leave, since V-E Day.

In order that The Journal may publish monthly as complete and accurate a list as possible of Ohio medical officers separated from the service, the active cooperation of medical officers themselves, their families and County Medical Society officers, in transmitting such information to the Columbus office of the Ohio State Medical Association, is solicited. Please send the information in promptly, so new names can be added to the list immediately.

Moreover, medical officers are again reminded that the Columbus Office is prepared to supply them with helpful information regarding post-graduate education opportunities and data on opportunities for establishing a practice.

In the following tabulation, the city in which the medical officer resided or practiced when he entered the service is given in most instances. If the physician, after separation, has changed location and this information is known, the place of relocation also is indicated. The rank shown is based on the latest information on file which, of course, may not be up to date in a few cases:

| Name                   | City                    | Rank                 |
|------------------------|-------------------------|----------------------|
| Adams, A. M.           | Lima.....               | Capt., A.U.S.        |
| Allen, Chester H.      | Portsmouth.....         | Major, A.U.S.        |
| Andrus, Willard B.     | Columbus.....           | Capt., A.U.S.        |
| Angerman, Walter       | Wooster.....            | Major, A.U.S.        |
| Archer, M. C.          | Medina.....             | Major, A.U.S.        |
| Arons, Abraham         | Cleveland.....          | Capt., A.U.S.        |
| Arthur, Robert D.      | Springfield.....        | Major, A.U.S.        |
| Atkins, Harry T.       | Cincinnati.....         | Lt. Comdr., U.S.N.R. |
| Axelson, Oscar A.      | Youngstown.....         | Capt., A.U.S.        |
| Axthelm, M. F.         | Caledonia.....          | Capt., A.U.S.        |
| Baurichter, Francis X. | Cincinnati.....         | Capt., A.U.S.        |
| Benedetto, Eugene R.   | Alliance.....           | Capt., A.U.S.        |
| Benjamin, Julien E.    | Cincinnati.....         | Col., A.U.S.         |
| Beren, Irwin B.        | Cincinnati.....         | Capt., A.U.S.        |
| Bennett, Kenneth E.    | Dover.....              | Capt., A.U.S.        |
| Berger, Peary B.       | Englewood.....          | Capt., A.U.S.        |
| Berns, Charles         | Cleveland.....          | Lt. Col., A.U.S.     |
| Berndt, Albert L.      | Portsmouth.....         | Major, A.U.S.        |
| Berlin, Fred P.        | Wapakoneta.....         | Major, A.U.S.        |
| Berry, Clyde W.        | Wapakoneta.....         | Major, A.U.S.        |
| Bershadsky, Solomon    | Cincinnati.....         | Capt., A.U.S.        |
| Best, Marshall M.      | Xenia.....              | Col., A.U.S.         |
| Black, Albert W.       | Centerville.....        | Capt., A.U.S.        |
|                        | (formerly Dayton)       |                      |
| Black, James A.        | Silverton.....          | Major, A.U.S.        |
| Blandford, S. E.       | Cleveland.....          | Major, A.U.S.        |
| Bockoven, H. D.        | Verona.....             | Capt., A.U.S.        |
| Bolton, Ralph D.       | Canton.....             | Major, A.U.S.        |
| Bonar, L. D.           | Mansfield.....          | Capt., A.U.S.        |
| Bookwalter, Henry L.   | Columbiana.....         | Capt., A.U.S.        |
| Brettell, Howard W.    | Steubenville.....       | Major, A.U.S.        |
| Brown, Arthur A.       | Columbus.....           | Lt. Col., A.U.S.     |
|                        | (formerly Canal Fulton) |                      |
| Brown, W. H.           | Bowling Green.....      | Capt., A.U.S.        |
| Browne, K. B.          | Whitehouse.....         | 1st Lt., A.U.S.      |
| Brubaker, Elber R.     | Springfield.....        | Lt. Comdr., U.S.N.R. |

| Name                       | City                           | Rank                 |
|----------------------------|--------------------------------|----------------------|
| Brugler, Guy               | Cleveland.....                 | Major, A.U.S.        |
| Brumbaugh, Jos. J.         | Canton.....                    | Lt. Col., A.U.S.     |
| Brumm, Lewis P.            | Cincinnati.....                | Capt., A.U.S.        |
| Buchanan, Richard R.       | Cincinnati.....                | 1st Lt., A.U.S.      |
| Burnstein, M. D.           | Columbus.....                  | Major, A.U.S.        |
| Calland, Wm. R.            | Barberton.....                 | Major, A.U.S.        |
| Callander, A. R.           | Delaware.....                  | Lt. Col., A.U.S.     |
| Calo, Frank J.             | East Cleveland.....            | Capt., A.U.S.        |
| Carlisle, Richard C.       | Columbus.....                  | Major, A.U.S.        |
| Carter, William H.         | Gahanna.....                   | Major, A.U.S.        |
|                            | (formerly Cleveland)           |                      |
| Chalker, Harry E.          | Girard.....                    | Major, A.U.S.        |
| Chambers, David A.         | Cleveland.....                 | Col., A.U.S.         |
| Champion, P. K.            | Dayton.....                    | Capt., A.U.S.        |
| Chappel, Merwin R.         | Athens.....                    | Major, A.U.S.        |
| Coddington, Oscar L.       | Columbus.....                  | Capt., A.U.S.        |
| Colla, Joseph              | Youngstown.....                | Capt., A.U.S.        |
| Conaway, E. E.             | Cambridge.....                 | Capt., A.U.S.        |
| Damerow, Wesley P.         | Cincinnati.....                | Capt., A.U.S.        |
| Damitz, J. C.              | Akron.....                     | Lt. Comdr., U.S.N.R. |
| D'Amore, A. P.             | Masury.....                    | Capt., A.U.S.        |
|                            | (taking postgraduate training) |                      |
| Danchik, S. A.             | Columbus.....                  | Capt., A.U.S.        |
| Davies, Drew L.            | Columbus.....                  | Comdr., U.S.N.R.     |
| DeCicco, Gabriel E.        | Youngstown.....                | Capt., A.U.S.        |
| DeMeter, Steven R.         | Cleveland.....                 | Major, A.U.S.        |
| Deishley, Charles J.       | Columbus.....                  | Major, A.U.S.        |
| Denny, William L.          | Cambridge.....                 | Major, A.U.S.        |
| Ditch, Edward G.           | Caldwell.....                  | Capt., A.U.S.        |
| Doering, J. Ward           | Logan.....                     | Major, A.U.S.        |
| Dole, John A.              | Ironton.....                   | Major, A.U.S.        |
| Dowell, Lloyd L.           | Grove City.....                | Capt., A.U.S.        |
| Downey, Frank S.           | Sidney.....                    | Capt., A.U.S.        |
| Downing, John S.           | Akron.....                     | Major, A.U.S.        |
| Dunn, David Dennis         | Cleveland.....                 | Capt., A.U.S.        |
| Dworkin, Harry             | Cincinnati.....                | Capt., A.U.S.        |
| Eastman, Robert L.         | Mount Vernon.....              | Major, A.U.S.        |
| Eckstein, Richard W.       | Cleveland.....                 | Capt., A.U.S.        |
| Engel, W. J.               | Cleveland.....                 | Comdr., U.S.N.R.     |
| Epstein, Samuel            | Youngstown.....                | Capt., A.U.S.        |
| Ersay, Emil F.             | Cleveland.....                 | Major, A.U.S.        |
| Everett, Clyde W.          | Cleveland.....                 | Lt. Col., A.U.S.     |
| Extelt, Andrew W.          | Toledo.....                    | Capt., A.U.S.        |
| Ferraro, Wm. R.            | Canton.....                    | Major, A.U.S.        |
| Firestone, B. I.           | Youngstown.....                | Capt., A.U.S.        |
| Fitzgerald, George P., Jr. | Springfield.....               | Capt., A.U.S.        |
| Foor, Clifford G.          | Hillsboro.....                 | Lt. Col., A.U.S.     |
| Forteza, Rosendo, Jr.      | Cincinnati.....                | Major, A.U.S.        |
| Francis, Carl C.           | Cleveland.....                 | Lt. Col., A.U.S.     |
| Freedman, Mark A.          | Columbus.....                  | Lt. Col., A.U.S.     |
| Fridline, G. D.            | Ashland.....                   | Major, A.U.S.        |
| Friedman, David L.         | Toledo.....                    | Capt., A.U.S.        |
| Fritz, W. A.               | Wooster.....                   | Major, A.U.S.        |
| Fronek, O. J.              | Cleveland.....                 | Lt. Comdr., U.S.N.R. |
| Frush, R. E.               | Lexington.....                 | 1st Lt., A.U.S.      |
| Galinson, S. H.            | Dayton.....                    | Capt., A.U.S.        |
| Garvin, Gilbert E.         | Blanchester.....               | Capt., A.U.S.        |
| Ginn, Guy A.               | Springfield.....               | Capt., A.U.S.        |
| Ginsburg, Matthew          | Toledo.....                    | Major, A.U.S.        |
| Glicksberg, E. L.          | Cleveland.....                 | 1st Lt., A.U.S.      |
| Goldberg, Samuel D.        | Youngstown.....                | Major, A.U.S.        |
| Graller, David             | Cincinnati.....                | Major, A.U.S.        |
| Gressle, George A.         | Newark.....                    | Major, A.U.S.        |
| Greenberg, Marcel          | Cleveland.....                 | Major, A.U.S.        |
| Greenfield, Jack           | Cleveland.....                 | Capt., A.U.S.        |
| Grice, Francis V.          | Dayton.....                    | Capt., A.U.S.        |
| Gustafson, Milton H.       | Cleveland.....                 | Capt., A.U.S.        |
| von Haam, Emmerich         | Columbus.....                  | Major, A.U.S.        |
| Hall, Raymond A.           | Youngstown.....                | Capt., A.U.S.        |
| Haller, Harry A.           | Cleveland.....                 | Lt., U.S.N.R.        |
| Hamilton, John M.          | Cleveland.....                 | Capt., A.U.S.        |
| Hamilton, Joseph W.        | Akron.....                     | 1st Lt., A.U.S.      |
| Hamman, R. H.              | Waterville.....                | Capt., A.U.S.        |
| Hammersley, E. R.          | Tuscarawas.....                | Comdr., U.S.N.R.     |
| Hann, W. L.                | West Unity.....                | Lt., U.S.N.R.        |
| Hapke, Fred B.             | Troy.....                      | Major, A.U.S.        |
| Hardesty, H. H.            | Cleveland.....                 | Capt., A.U.S.        |
| Harris, Frank H.           | Martins Ferry.....             | Capt., A.U.S.        |
| Harrold, Arvine W.         | Tiffin.....                    | Capt., A.U.S.        |
| Hartzler, Adrian J.        | Wooster.....                   | Major, A.U.S.        |
| Haubrich, Robert C.        | Pataskala.....                 | Major, A.U.S.        |
| Hauman, H. L.              | Toledo.....                    | Major, A.U.S.        |
| Henrie, Charles C.         | Celina.....                    | Capt., A.U.S.        |
| Herrmann, Walter L.        | Portsmouth.....                | Surg., U.S.P.H.S.    |
| Hershberger, Ralph E.      | Tiffin.....                    | Capt., A.U.S.        |
| Heywood, Howard W.         | Cincinnati.....                | Capt., A.U.S.        |
| Hoffman, Henry L.          | Cleveland.....                 | Major, A.U.S.        |
| Holmberg, Robert E.        | Cleveland.....                 | Major, A.U.S.        |
| Horowitz, Martin M.        | Columbus.....                  | Capt., A.U.S.        |
| Hunter, George G.          | Ironton.....                   | Major, A.U.S.        |



| Name                   | City                      | Rank                 | Name                   | City                    | Rank                 |
|------------------------|---------------------------|----------------------|------------------------|-------------------------|----------------------|
| Hutt, Herbert B.       | Youngstown.....           | Capt., A.U.S.        | Salsbery, Otto H.      | Norwood.....            | 1st Lt., A.U.S.      |
| Ipp, Herman H.         | Youngstown.....           | Major, A.U.S.        | Sanders, John H.       | Rocky River.....        | Major, A.U.S.        |
| Jablonski, C. R.       | Cleveland.....            | Capt., A.U.S.        | Sating, Robert J.      | Cleveland Heights.....  | Capt., A.U.S.        |
| Jacoby, Ben E.         | Marion.....               | Lt., U.S.N.R.        | Schaen, Irvin R.       | Middletown.....         | Capt., A.U.S.        |
|                        | (formerly Columbus)       |                      | Scheetz, Maurice E.    | Lima.....               | Capt., A.U.S.        |
| Johnson, F. A.         | Akron.....                | Major, A.U.S.        |                        | (formerly Kalida)       |                      |
| Johnston, Albert M.    | Marysville.....           | Lt. Col., A.U.S.     | Schneider, L. W.       | Hamilton.....           | Major, A.U.S.        |
| Kalb, Nathan           | Columbus.....             | Capt., A.U.S.        | Schultz, William R.    | Wooster.....            | Capt., A.U.S.        |
|                        | (formerly Cygnet)         |                      | Schumaker, William H.  | Canton.....             | Capt., A.U.S.        |
| Kaplan, Ronald R.      | Cleveland Heights.....    | Major, A.U.S.        | Scott, H. M.           | Toledo.....             | Major, A.U.S.        |
| Karam, Harvey A.       | Akron.....                | Capt., A.U.S.        | Scott, R. P.           | Norwalk.....            | Capt., A.U.S.        |
| Karlan, A. M.          | Springfield.....          | Capt., A.U.S.        | Selfman, Albert        | Mansfield.....          | Capt., A.U.S.        |
| Katz, Louis B.         | Dayton.....               | Capt., A.U.S.        | Shamansky, Harry S.    | Columbus.....           | Major, A.U.S.        |
| Katzenmeyer, Walter R. | Shaker Heights.....       | Capt., A.U.S.        | Shanahan, E. J.        | Clyde.....              | Capt., A.U.S.        |
| Kemp, Hardy A.         | Detroit, Mich.....        | Lt. Col., A.U.S.     | Sharretts, Kenneth C.  | Cincinnati.....         | Major, A.U.S.        |
|                        | (formerly Columbus)       |                      | Shively, R. L.         | Toledo.....             | Major, A.U.S.        |
| Kirkendall, E. T.      | Columbus.....             | Col., A.U.S.         | Shroder, L. N.         | Greenville.....         | Capt., A.U.S.        |
| Klopper, Edward        | Columbus.....             | Capt., A.U.S.        | Simon, Karl J.         | Canton.....             | Capt., A.U.S.        |
| Knapp, J. D.           | Seneca ville.....         | Capt., A.U.S.        | Slivka, James E.       | Cleveland.....          | Lt., U.S.N.R.        |
|                        | (formerly Lore City)      |                      | Smith, Birna R.        | Lewisburg.....          | Capt., A.U.S.        |
| Knickerbocker, T. W.   | Cleveland.....            | Major, A.U.S.        | Smith, G. R.           | Painesville.....        | Major, A.U.S.        |
| Knisely, Earl P.       | Columbus.....             | Major, A.U.S.        | Sokol, C. R.           | Youngstown.....         | Major, A.U.S.        |
| Krakoff, Morris A.     | Columbus.....             | Capt., A.U.S.        | Spangler, Fred E.      | Lancaster.....          | Major, A.U.S.        |
| Kremer, John A.        | Ada.....                  | Capt., A.U.S.        |                        | (formerly Somerset)     |                      |
| Kreindler, Louis       | Cincinnati.....           | Major, A.U.S.        | Sparks, Edw. P., Jr.   | Sidney.....             | Capt., A.U.S.        |
| Kuby, William H.       | Cincinnati.....           | Capt., A.U.S.        | Spyker, Mitchell A.    | Columbus.....           | Capt., A.U.S.        |
| Kumpe, Carl W.         | Hillsboro.....            | Major, A.U.S.        | Stine, George Thomas   | Columbus.....           | Lt. Col., A.U.S.     |
| Lawrence, Leslie L.    | Canton.....               | Major, A.U.S.        | Stolzar, Irwin H.      | Cleveland.....          | Capt., A.U.S.        |
| Leech, Charles H.      | Lima.....                 | Major, A.U.S.        | Stratham, William H.   | Toledo.....             | Lt. Col., A.U.S.     |
| Lemon, George H.       | Fayette.....              | Capt., A.U.S.        | Stukenborg, Frank X.   | Toledo.....             | Capt., A.U.S.        |
| LeSar, George W., Jr.  | Cleveland.....            | Capt., A.U.S.        | Surington, Cyril       | Columbus.....           | Major, A.U.S.        |
| Lichtblau, Abe A.      | Canton.....               | Capt., A.U.S.        | Taylor, Howard P.      | Cleveland.....          | Lt. Col., A.U.S.     |
| Limbacher, Henry P.    | Cleveland.....            | Major, A.U.S.        | Thomas, Berger         | Columbus.....           | Lt. Comdr., U.S.N.R. |
| Lord, Raymond S.       | Fredericktown.....        | Capt., A.U.S.        | Thomas, Max S.         | Akron.....              | Major, A.U.S.        |
| Leonard, D. E.         | Cuyahoga Falls.....       | Capt., A.U.S.        | Topinka, John A.       | University Heights..... | Capt., A.U.S.        |
| Lulenski, Chester R.   | Cleveland.....            | Capt., A.U.S.        | Tuckerman, Jacob B.    | Cleveland.....          | Capt., A.U.S.        |
| Lustberg, Alfred       | Cincinnati.....           | Capt., A.U.S.        | Turel, Stanley E.      | Cleveland.....          | Capt., A.U.S.        |
| Lyon, E. E.            | Toledo.....               | Major, A.U.S.        | Udelf, Maxwell S.      | Cleveland.....          | Major, A.U.S.        |
| McElroy, Wm. D.        | Youngstown.....           | Lt. Col., A.U.S.     | Van Buren, H. K.       | Carey.....              | Capt., A.U.S.        |
| de Maine, P. B.        | Akron.....                | Capt., A.U.S.        | Van Epps, Herbert F.   | Dover.....              | Major, A.U.S.        |
| McCalley, W. C.        | Cleveland.....            | Col., A.U.S.         | Vigor, William N.      | Brecksville.....        | Major, A.U.S.        |
| McCormish, Cletus T.   | Cuyahoga Falls.....       | Capt., A.U.S.        | Wagner, Richard L.     | Portsmouth.....         | Major, A.U.S.        |
| McKee, Wilbur E.       | Louisville, Kentucky..... | Major, A.U.S.        | Watson, George B.      | Columbus.....           | Capt., A.U.S.        |
|                        | (formerly Bryan)          |                      | Weinberg, Norman H.    | Cincinnati.....         | Major, A.U.S.        |
| Machle, Willard F.     | Cincinnati.....           | Col., A.U.S.         | Weiser, Richard W.     | Jewett.....             | Major, A.U.S.        |
| Marcus, L. L.          | Toledo.....               | Major, A.U.S.        |                        | (formerly Cincinnati)   |                      |
| Markey, Leo R.         | Cleveland.....            | Lt. Col., A.U.S.     | Weiss, Adam F.         | Marietta.....           | Capt., A.U.S.        |
| Markey, Robert C.      | Dayton.....               | Capt., A.U.S.        | Wheeler, William W.    | Cleveland.....          | Major, A.U.S.        |
| Markley, William W.    | Cleveland.....            | Capt., A.U.S.        | Whitehouse, Stanley W. | Cincinnati.....         | Capt., A.U.S.        |
| Martin, John E.        | Bexley.....               | Major, A.U.S.        | Wilkinson, Herman E.   | Van Wert.....           | Lt. Col., A.U.S.     |
| Masters, W. Eugene     | Columbus.....             | Comdr., U.S.N.R.     | Williams, Harold L.    | Lafayette.....          | Capt., A.U.S.        |
| Meiling, R. L.         | Columbus.....             | Lt. Col., A.U.S.     | Williams, Robert E.    | Barberton.....          | Capt., A.U.S.        |
| Miller, Isadore        | Urbana.....               | Capt., A.U.S.        | Wilson, Gerald W.      | Columbus.....           | Major, A.U.S.        |
| Miller, Lawrence H.    | Granville.....            | Capt., A.U.S.        | Wirtz, R. E.           | Canton.....             | Capt., A.U.S.        |
| Montgomery, Henry K.   | Dayton.....               | Capt., A.U.S.        | Witwer, R. G.          | Cleveland.....          | Lt. Comdr., U.S.N.R. |
| Myers, Ben V.          | Elyria.....               | Lt. Col., A.U.S.     | Worstell, Henry P.     | Columbus.....           | Comdr., U.S.N.R.     |
| Neal, William J.       | Archbold.....             | Capt., A.U.S.        | Wright, Herbert B.     | Cleveland.....          | Col., A.U.S.         |
| Neff, Garnett E.       | Portsmouth.....           | Capt., A.U.S.        | Wright, Orville M.     | Dayton.....             | Comdr., U.S.N.R.     |
| Neill, William A.      | Toledo.....               | Capt., A.U.S.        | Wyker, Albertus C.     | Columbus.....           | Capt., A.U.S.        |
| Nelson, G. G.          | Youngstown.....           | Major, A.U.S.        | Yarris, W. F.          | Fostoria.....           | Lt. (j.g.), U.S.N.R. |
| Nieman, Roland Edward  | Cincinnati.....           | Major, A.U.S.        | Yasinow, Aaron B.      | Cleveland.....          | Capt., A.U.S.        |
| Nipple, V. C.          | Midvale.....              | Capt., A.U.S.        | Yaw, Owen F.           | Logan.....              | Major, A.U.S.        |
| Obenour, Sterling      | Zanesville.....           | Comdr., U.S.N.R.     |                        | (formerly Cincinnati)   |                      |
| Oberson, E. C.         | Cleveland.....            | Major, A.U.S.        | Zeiger, Michael R.     | Cleveland.....          | Major, A.U.S.        |
| Ondash, Stephen W.     | Youngstown.....           | Major, A.U.S.        | Zeller, Ross M.        | Greenville.....         | Capt., A.U.S.        |
| Park, James H.         | Ashtabula.....            | Lt. Col., A.U.S.     |                        |                         |                      |
| Partington, Philip F.  | Shaker Heights.....       | Major, A.U.S.        |                        |                         |                      |
| Pater, Joseph L.       | Hamilton.....             | Capt., A.U.S.        |                        |                         |                      |
| Patterson, O. F.       | Holmesville.....          | Major, A.U.S.        |                        |                         |                      |
| Peabody, Carroll A.    | Shaker Heights.....       | Capt., A.U.S.        |                        |                         |                      |
| Pennington, William A. | Marion.....               | Capt., A.U.S.        |                        |                         |                      |
| Peters, George S.      | Massillon.....            | Lt. Comdr., U.S.N.R. |                        |                         |                      |
| Peterson, Guy S., Jr.  | Cleveland.....            | Capt., A.U.S.        |                        |                         |                      |
| Piatt, Arnold D.       | Newark.....               | Capt., A.U.S.        |                        |                         |                      |
| Pimsner, Arthur A.     | Lakewood.....             | Lt. Col., A.U.S.     |                        |                         |                      |
| Pinkerton, A. W.       | Lima.....                 | Major, A.U.S.        |                        |                         |                      |
| Pinnell, Earl E.       | Dayton.....               | Capt., A.U.S.        |                        |                         |                      |
|                        | (formerly Cleveland)      |                      |                        |                         |                      |
| Piraino, Anthony       | Oberlin.....              | Capt., A.U.S.        |                        |                         |                      |
| Plymale, Jay L.        | Marion.....               | Major, A.U.S.        |                        |                         |                      |
| Potter, F. A.          | Toledo.....               | Major, A.U.S.        |                        |                         |                      |
| Powell, James G.       | Painesville.....          | Capt., A.U.S.        |                        |                         |                      |
| Puppel, A. D.          | Ashley.....               | Major, A.U.S.        |                        |                         |                      |
| Radecki, Joseph A.     | Toledo.....               | Capt., A.U.S.        |                        |                         |                      |
| Raitz, R. E.           | Cincinnati.....           | Capt., A.U.S.        |                        |                         |                      |
| Reeder, Paul A.        | Barnesville.....          | Capt., A.U.S.        |                        |                         |                      |
| Reese, Walter A.       | Middletown.....           | Lt. Col., A.U.S.     |                        |                         |                      |
| Reiling, Walter A.     | Dayton.....               | Major, A.U.S.        |                        |                         |                      |
| Root, Joseph C.        | Cleveland.....            | Comdr., U.S.N.R.     |                        |                         |                      |
| Rosenblum, Morris S.   | Youngstown.....           | Capt., A.U.S.        |                        |                         |                      |
| Rosewater, Ralph S.    | Lakewood.....             | 1st Lt., A.U.S.      |                        |                         |                      |
| Roth, Carl W.          | Columbus.....             | Capt., A.U.S.        |                        |                         |                      |
| Rubin, Herman G.       | Akron.....                | Major, A.U.S.        |                        |                         |                      |
| Rubin, Nathan A.       | Canton.....               | 1st Lt., A.U.S.      |                        |                         |                      |
| Ryan, James E.         | Sandusky.....             | Major, A.U.S.        |                        |                         |                      |
| Ryan, William J.       | Akron.....                | Capt., A.U.S.        |                        |                         |                      |
| Sadugor, Marvin G.     | Cleveland.....            | Major, A.U.S.        |                        |                         |                      |
| Sage, Harry W.         | Columbus.....             | Comdr., A.U.S.       |                        |                         |                      |

## Grant for Biochemistry Received

The Elisabeth Severance Prentiss Foundation of Cleveland has made a grant, which will probably amount to \$500,000, to finance a greatly expanded department of biochemistry in the School of Medicine, Western Reserve University.

President Winfred G. Leutner of Western Reserve said an "outstanding man" in the field of biochemistry will be employed as head of the department with an able corps of assistants. The money will be paid to the university in quarterly payments over a period of 10 years, "subject to certain conditions". The chair of biochemistry was left vacant recently with the appointment of Dr. Victor C. Myers as head of a new department of clinical biochemistry.



# General Hawley Addresses Conference of County Society Officers; Public Relations and Expansion of the State Association's Work Among Other Topics Discussed

**A**PPROXIMATELY 150 physicians demonstrated their interest in the future of medicine in Ohio by attending a Conference of County Medical Society Presidents and Secretaries sponsored by the Ohio State Medical Association at the Deshler-Wallick Hotel, Columbus, Sunday, November 11. The group included representatives of most of the local societies and officers, members of The Council, delegates to the American Medical Association and members of committees of the State Association.

Dr. Edgar P. McNamee, Cleveland, President-Elect of the State Association, presided at the morning session and opened the conference with a brief address of welcome. He stated that the purpose of the meeting was to stimulate activity among the various societies through the exchange of ideas and by giving the leaders in medical organization the latest available information on some of the more vital issues which confront the medical profession today.

## HENDRICKS FIRST SPEAKER

The first speaker was Thomas A. Hendricks, Chicago, Secretary of the Council on Medical Service and Public Relations of the American Medical Association, and for 17 years Executive Secretary of the Indiana State Medical Society. His subject was: "Public Relations: The Need For It and How the Job Should Be Done".

Citing what can be done by "combined operations and coordinated effort" of the various state and local medical societies, Mr. Hendricks stated that he was convinced of the following three facts:

1. The profession must be positive rather than negative; not on the defensive, but on the aggressive.
2. That public relations is not a one-man job, but a job for each of the 160,000 doctors in America.
3. That any time American Medicine, with its tremendous potential strength, goes into battle, it can win, provided it wages its battle in the interest of public welfare.

## EACH SOCIETY NEEDS COMMITTEE

Mr. Hendricks told of the regional conferences which the Council on Medical Service and Public Relations has held throughout the country, and the development of the A.M.A.'s 14-point program. He urged the formation of an active committee on public relations by every county medical society, and that all available local re-

sources in the press, radio and luncheon clubs should be used to publicize the medical viewpoint. The initiative of the Ohio medical profession in forming Ohio Medical Indemnity, Inc., was praised by Mr. Hendricks as the type of constructive and aggressive action by the doctors themselves, which will prove to the public that they do not have to assume the burden of a governmental medical system in order to get the protection they desire.

Supplementing Mr. Hendricks' remarks, Dr. Edward J. McCormick, Toledo, Chairman of the Council on Medical Service and Public Relations, made a plea for a unified and militant profession, and advocated a public relations program within the medical profession itself as well as with the public. He, too, urged an aggressive, positive national program.

## "OHIO HAS A JOB TO DO"

"We Have A Job To Do In Ohio; What Are We Going To Do About It", was the topic of an address made by Dr. L. Howard Schriver, Cincinnati, President of the State Association.

"In order to fulfill its public functions, American Medicine must at the same time serve itself", declared Dr. Schriver. He pointed out that while the profession, individually and collectively, has contributed invaluable therapeutic, scientific and educational services to the public welfare, the future position of medicine in our national economy is imperiled. This situation is due, Dr. Schriver stated, to the fact that the physicians of the country have concentrated their efforts on the above services and have neglected the newly discovered important functions of public relations.

He continued:

"We must arouse in the individual physician and in our representative organizations a full realization that not only is the private practice of medicine jeopardized but with it individual freedom of all people is also endangered. I am sincerely of the opinion that medical practice has made one of the great contributions to a free and democratic civilization. However, we can not be satisfied with this accomplishment alone. From our scientific knowledge and everyday observation we must recognize certain inadequacies in our social economy exist. Although not primarily medical, these have a direct relationship to the health and happiness of the community.

"In order to improve our public relations we must have the courage to direct public thought to these correctable conditions. I have in mind both material commodities and cultural activities such as nutrition, housing and education.

Without improvement in these spheres of human endeavor, medicine can never render its potential service. Organized medicine has lent its consultative assistance to any and all recognized agencies, whether private or governmental, interested in the improvement of health. This alone, in my opinion, is not sufficient. Organized medicine fortified with scientific knowledge in the field of health as no other group can be, must assume aggressive and vigorous leadership in these activities rather than to only lend assistance and advice.

#### MUST TAKE INTEREST IN POLITICS

"The medical profession, individually and collectively, must take a keener interest and more active participation in the social and economic aspects of politics. This is possible without participation in partisan politics, which should never be indulged in by the medical profession as an organized group. However, as citizens, we should exercise an intensive interest in the selection of our legislative representatives. I might add that if the American people had exercised this prerogative more intelligently in recent years it is probable we would not find ourselves in our present state of confusion and disunity.

"If we desire to prevent regimentation of medical practice it is not sufficient to object to it; we must be ready to present sound arguments and scientific data that will convince both the public and our legislative representatives that regimentation will not only fail to improve the health of our people but will instead lower health standards.

#### GOOD PUBLIC RELATIONS VITAL

Stating that one of the greatest errors of omission committed by the medical profession is that of not establishing good public relations, Dr. Schriver went on to say:

"We have permitted ourselves to become separated from the public instead of maintaining an intimate relationship with the public. It is very interesting to note that the public has an almost reverent respect for the individual physician and yet has no particular respect nor trust in medical organization. Individually, we would seem to be stronger in public relations than we are collectively. The public in general has no information about the functions of organized medicine. Unfortunately, in the lay press other than physicians usually speak for medicine on subjects other than scientific. As a result, in the opinion of the layman, the medical profession is hidebound, reactionary, etc., when as a matter of fact the medical profession is truly liberal in its philosophy, believing in the preservation of individual liberty and respect for the dignity of man. There is no greater liberal than he who subscribes to this philosophy."

#### WANTS BUREAU REVIVED

The responsibility for improving the public relations of the medical profession in Ohio should be accepted by the Ohio State Medical Association and every county medical society in the state, Dr. Schriver said. He advocated the reestablishment of a department of public relations in the State Headquarters Office, to employ any and all recognized channels such as radio,

public press, pamphlet distribution, organization of a speakers' bureau, etc, to disseminate information on medicine and health, the policies and attitude of the medical profession in respect to legislation and other information of public interest.

#### EXPANDED PROGRAM ADVOCATED

Dr. Schriver recommended a substantial increase in the dues of the State Association to provide additional personnel and facilities to meet the rapidly expanding functions of the State Headquarters Office. He pointed out that due to the waiver of dues of members in military service, the Association's income was reduced materially and that the reserve funds were depleted by the contribution of \$35,000 to Ohio Medical Indemnity, Inc. Dr. Schriver stated that only four states have lower dues than Ohio, and enumerated state dues or assessments in other states as follows: California, \$100; Connecticut, \$20; Illinois, \$8; Indiana, \$15; Kentucky, \$10; Massachusetts, \$10; Michigan, \$37; Minnesota, \$15; Nebraska, \$15; New York, \$10; Pennsylvania, \$20; Rhode Island, \$25; Texas, \$20; Washington, \$20; West Virginia, \$15; Wisconsin, \$33.

"The many and complex functions of the Ohio State Medical Association can not be executed on \$7 dues. . . . It is impossible to render the quality of service I am certain you expect of your State Association unless we increase the number of our employees and expand our facilities", Dr. Schriver said.

Dr. Schriver concluded his address with a strong plea that county societies exercise the greatest of care in the selection of officers, committeemen, Councilors and representatives to various organizations. "These men must be interested, well-informed, and above all, willing to work", he said.

#### GENERAL HAWLEY IS SPEAKER

Following a luncheon, the afternoon session began with an address on "The Medical Program of the Veterans Administration", by Maj. Gen. Paul R. Hawley, M.C., U.S.A., Washington, D.C., Medical Director of the United States Veterans Administration. In introducing Gen. Hawley, Dr. Schriver praised his medical career and his outstanding record as chief surgeon in the European Theater of Operations.

"The care of the veteran, the greatest medical problem in history, requires the public service of the medical profession as a whole", declared Gen. Hawley. He stated that there are three phases of the problem: hospitalization, outpatient treatment and rehabilitation.

Gen. Hawley explained the fallacy of the past policy of the Veterans Administration in locating hospitals presumably in centers of veteran



population, but actually, through political pressures many were remotely located. He believes that the hospitals should be located near to medical centers and medical schools, so that the services of local consultants can be used. He favors also the establishment of approved residencies in veterans hospitals.

#### WANTS ALL DOCTORS TO HELP

On the question of out-patient care, Gen. Hawley said that he did not favor the procedure in the past by which one or two physicians were designated as Veterans Administration physicians in a community. He believes that every veteran is entitled to choose his own physician, and that every physician in a community should be a Veterans Administration physician. Gen. Hawley referred to the Monmouth County, N.J., plan (see *O.S.M.J.*, Nov., 1945, issue, pp. 1035-6) in which the county medical society established and operated an out-patient clinic. He said that the Government will agree to any plan at all reasonable which fits a particular community and provides adequate out-patient care to veterans. Gen. Hawley also stated that he was trying to simplify and minimize the amount of paper work required of physicians who treat veterans. He said he needed and welcomed the active help of all state and county medical societies.

Gen. Hawley concluded his address with an appeal to the medical profession to assist the Veterans Administration by: First, keeping care of the veterans out of politics. The best medical care in this country can be had only by the cooperation of the splendid men in the medical profession assisting in the hospitals and out-patient service, he said. Second, helping educate the public that a Veterans Administration hospital is not an asset to a community unless it is located where it can give the veteran the best possible care.

#### TALK ON OHIO MEDICAL INDEMNITY

Charles H. Coghlan, Columbus, Executive Vice-President of Ohio Medical Indemnity, Inc., closed the conference with an explanation of the surgical and obstetrical contract to be offered by that company. He announced that Ohio Medical Indemnity, Inc., was licensed by the State Superintendent of Insurance to do business in Ohio as of Nov. 8, and that as soon as final details of the administrative agreement with Blue Cross have been determined, solicitation of subscribers will begin in the Cincinnati area. Eventually the indemnity policy will be offered in cooperation with eight of the nine Ohio Blue Cross plans. The exception is the district in which the Cleveland Hospital Service Plan operates. That plan has organized its own mutual insurance company to provide surgical and obstetrical insurance. Mr. Coghlan emphasized that the bene-

fits of Ohio Medical Indemnity, Inc., would be sold to rural groups as well as in the metropolitan areas, and that these benefits would be expanded just as soon as experience justified such expansion. (A complete story on Ohio Medical Indemnity, Inc., with a detailed explanation of the subscriber's contract and the indemnity schedule will be found elsewhere in this issue of *The Journal*.)

#### Licensed Through Endorsement

The following physicians have been granted licenses to practice in Ohio by the State Medical Board through endorsement of their licenses to practice in other states: Lewis E. Abram, Cleveland, Univ. of Georgia; John M. Adams, Springfield, Jefferson Med. Coll.; Paul F. Baehren, Toledo, St. Louis Univ.; Scott R. Barrett, Cuyahoga, Meharry Med. Coll.; Robert H. Beck, Cleveland, Temple Univ.; Fowler A. Biggs, Montgomery, Howard Univ.; Harold F. Chase, Geauga, Boston Univ.; Leo V. English, Jr., Toledo, Howard Univ.; Mark Wm. Garry, Columbus, Marquette Univ.; Bernard S. Goffen, Middleport, New York Univ.; Donald E. Goley, Columbus, Coll. of Med. Evangelists; Charles H. Heffron, Toledo, Univ. of Louisville; Elmer F. Herring, E. Liverpool, Hahnemann Med. Coll.; Stephen A. Hilton, Cleveland, Univ. of Pittsburgh; John H. Holzaepfel, Columbus, Univ. of Michigan; Willis F. Hume, Hamilton, Harvard Med. School; Wm. Coolidge Humphries, Lakewood, Univ. of Maryland; Jerome N. Janson, Cincinnati, St. Louis Univ.

Wm. Smith Jasper, Sr., Lancaster, Geo. Washington Univ.; Edward C. Kasper, Cleveland, St. Louis Univ.; Norman G. Linton, Jamestown, Univ. of Louisville; Robert M. Manuel, Columbus, Howard Univ.; Edgar J. March II, Canton, Univ. of Rochester; Hal Burnis McLean, Cleveland, Univ. of Kansas; Christian R. Moorhead, Lima, Meharry Med. Coll.; Rankin A. Nebinger, Roseville, Jefferson; Grant E. Parsons, Cleveland, Temple Univ.; Frank B. Patterson, Columbus, Univ. of Pittsburgh; Alex Pohowsky, Jr., Cincinnati, Jefferson Med. Coll.; Marvin DaCosta Shie, Jr., Cleveland, Western Reserve Univ.; Robert Dewey Taylor, Cleveland, Northwestern; André A. Weil, Cleveland, Univ. of Berne, Switzerland; Arnold D. Welch, Cleveland, Washington Univ., Mo.; Myron Wilkoff, Youngstown, Colorado State Univ.; Ernest Wolff, Cleveland, Albert Ludwigs Univ., Germany.

Cleveland—"Backward Glimpse at Military Surgery", was the topic discussed by Dr. John H. Lazzari at a meeting of the Emerson Junior High P.T.A. Overseas 40 months, Dr. Lazzari originally was with the Fourth General Hospital, and later became chief of surgery of the 35th General Hospital in Lae, New Guinea.

# Deferments for Hospital Residency To End April 1 Under New Procurement and Assignment Program; Returning Veterans To Be Source of Supply; Details Outlined

**R**ECONVERSION of the 9-9-9 Program under which hospitals operated during most of the war and which provided a minimum supply of interns and residents for them during that period will begin on April 1, 1946, or sooner if conditions warrant.

Complete details with respect to the reconversion program were outlined in Bulletin No. 382 issued by the Procurement and Assignment Service for Physicians and transmitted to all Ohio hospitals under date of November 13.

In that bulletin, regulations pertaining to the make-up of intern and resident staffs of hospitals after April 1, 1946 were outlined. Hospitals were warned that they must begin at once to appoint returning medical officers to residencies so that, with rare exceptions, every military resident can be called to active duty not later than April 1. The bulletin stated that after July 1, 1946, returning veterans will be practically the only source of supply of residents for civilian hospitals.

## INTERNSHIPS TO BE 12 MONTHS

After the reconversion program gets into full swing by July 1, internships will be on a 12-month basis.

For the present veterans will not count in hospital quotas. However, they should be counted in quotas when they replace deferred commissioned officers who have counted in quotas. A hospital may exceed its quota of residents after it has released its last deferred commissioned officer. Quotas will be the same as for the present period (July 1, 1945 to April 1, 1946).

Intern quotas must be maintained since there is no greater supply of interns and the available supply must be apportioned among the various hospitals.

## REGULATIONS IN DETAIL

Following is an abstract of the essential parts of Bulletin No. 382 which was addressed to hospital superintendents and which outlines the procedures governing interns and residents for the period starting next April:

1. The 9-9-9 Program must be reconverted as rapidly as possible.
2. The Surgeon General expects to call to active duty as rapidly as possible every commissioned officer serving as a resident and, therefore, veterans will represent practically the only source of supply with which to fill residencies.
3. Every commissioned officer serving as a resident prevents one more medical officer

who has been on active duty from returning to his civilian practice.

4. Large numbers of veterans are now and will become increasingly available to serve residencies.
5. Those officers who have been on active duty are available for continuing periods of service while those who have not will be ordered to active duty as soon as they are released.
6. The quicker you are able to adjust your situation so that you are not dependent upon medical officers who have not been on active duty the sooner you will be able to operate on a peacetime basis.

## REASON FOR 9-9-9 PROGRAM

The 9-9-9 Program was devised in order to supply American hospitals with residents. Without it, every commissioned officer, which represented eighty per cent of each class, would have been called to active duty at the end of twelve months of internship, and the American hospitals would have been practically devoid of residents. The Procurement and Assignment Service made arrangements with the Surgeons General so that a sufficient number of officers could have their active duty orders delayed and the hospitals could have a minimum supply of residents with which to operate during the war. The whole plan constituted a loan of military personnel to civilian institutions by the Surgeons General, and they were willing to enter into the plan because it was perfectly obvious that there was no other supply available with which to keep these hospitals operating.

With the advent of V-J Day, it is imperative that we return to a peacetime plan at the earliest possible moment and, at the same time, permit the Surgeons General to pick up their officers as rapidly as possible. Increasing numbers of veterans who have seen active duty are becoming available for filling such positions and, therefore, the Surgeons General are convinced that it is in order to call to active duty as rapidly as possible every commissioned officer who has not been on active duty.

## SHOULD APPOINT VETERANS PROMPTLY

Hospitals, therefore, must begin at once to appoint veterans to every staff position so that, with rare exception, every military resident can be called to active duty not later than April 1, 1946. As soon as a veteran has been adequately trained to replace a commissioned officer resident that officer should be called to active duty at





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once without regard to whether or not he has completed the full term of his present deferment. The hospital must notify the State Chairman for Physicians of the Procurement and Assignment Service of the availability of such officers at once. State Chairmen must watch these developments closely. At present veterans will not count in hospital quotas and it will be of great advantage to the hospitals to accept veterans as replacements for the officers who do count in quotas. The great advantage to hospitals in accepting veterans promptly is that they will be orientated to their position before April 1 in anticipation of the fact that after July 1 such veterans will be practically the sole source of supply of residents for civilian hospitals. Hospitals and commissioned officers now serving as residents are reminded that any contract with hospitals is wholly subsidiary to their legal obligation to the Army and Navy, and that each individual is subject to active duty orders at the discretion of the Surgeons General.

Please remember that present deferments were granted by the Surgeons General prior to V-E Day when there was no other supply available to the hospitals. Now that we are past V-E Day and V-J Day and another supply is available—the veterans—it is not in order to continue the deferment of those men who have not seen active duty. In many institutions veterans are applying by the scores for hospital appointments and hospitals should accept them to the greatest extent possible in anticipation of the fact that those not having been on active duty will be called.

#### HOW TO GET VETERAN RELEASED

In those cases where the hospital desires the services of an officer on active duty in the Army to fill a residency and the hospital is willing to release a deferred commissioned resident who has not been on active duty before the termination of his present deferment period in exchange and he is an officer (1) who has been on active duty for two years or more, (2) who is now stationed within continental United States, and (3) who would accept the appointment, a request for the release of that officer under War Department Circular 296 through the Procurement and Assignment Service will receive immediately prompt and favorable consideration by the Surgeon General of the Army. This replacement possibility does not extend to officers on duty with the Navy.

#### IN CASES OF EMERGENCY

The Procurement and Assignment Service will continue to recognize their responsibility toward the hospitals and those individual instances very limited in number in which hospitals are unable to secure a veteran after exhausting every effort or an officer who qualifies under War Department Circular 296, will be given consideration by

the Procurement and Assignment Service and the Offices of the Surgeons General. Subject to the above general provisions the reconversion from the 9-9-9 Program to a peacetime twelve-month service will be conducted in accordance with the following plan: (This outline applies to the April group. Information concerning those who finish their present term before April and after April will be released in the very near future.)

#### SECTION I: PLAN OUTLINED

- A. Each commissioned officer who is an intern terminating his nine months of internship on April 1, 1946, will continue in his present internship until July 1, 1946. (For exceptions, see below.)
- B. Each commissioned officer who is a junior resident terminating his junior residency on April 1 (if he has not already been replaced by a veteran prior to April 1) will be called to active duty on April 1 except in rare cases in which special request for his services is submitted to and approved by the Procurement and Assignment Service and the Surgeon General—such request to be effective only until he is replaced by a veteran and not beyond July 1, 1946.
- C. Each commissioned officer who is a senior resident and who is completing his 27 months of service in a hospital following graduation will be called to active duty on or about April 1, 1946, if not replaced prior to that date by a veteran.
- D. Senior students who graduate on or about April 1, 1946, are to be accepted for internship on that date. This new group of interns will be allowed to serve internships until July 1, 1947. This means that hospitals would have a maximum of twice their quota of interns from April to July and their quota of interns from July to the following July. In view of this and in order to maintain equitable distribution of the intern supply quotas for interns will be maintained at their present levels.

#### SECTION II: EXCEPTIONS NOTED

- A. The present interns (referred to in Paragraph A, Section I, above) will be called to active duty on July 1, 1946, except (1) those who are called to duty between April 1 and July 1 because the hospitals can not facilitate both the old and new groups of interns for three full months of overlapping service; and (2) those rare cases where their services are absolutely essential for an additional period in civilian hospitals. Their services will be deemed necessary only in those cases in which the Procurement and Assignment Service and the Surgeons General are convinced that every effort to obtain the services of veterans, physically disqualified



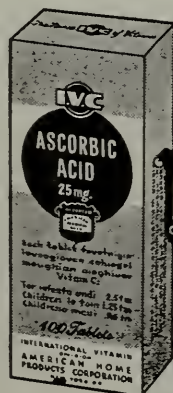
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or otherwise ineligible men or of women has been made. [N.B. If Congress votes funds to continue ASTP beyond June 30, 1946, the military group in the following class (unless the Army Training Service abandons its present acceleration demands) will become available for internship on January 1, 1947. This would produce a six-month overlap from January to July but it is hoped that this can be avoided.]

B. The present junior residents (referred to in Paragraph D, Section I, above) will be called to active duty as soon as replaced by a veteran with the same exceptions stated in Paragraph A, Section II, above.

C. (Blank).

D. The new graduates (referred to in Paragraph D, Section I, above), who will complete twelve months of internship on or before July 1, 1947, will be called to active duty on that date. These men may have as much as fifteen months of internship, that is, April 1, 1946 to July 1, 1947.

#### SECTION III: REGARDING QUOTAS

Please note that by April 1, 1946, you will be almost entirely dependent upon non-military personnel to fill residencies.

This program does not contemplate an interference with the present policy of not including veterans in quotas. In fact, it emphasizes the importance of acquiring the services of such veterans at the earliest possible moment so that they will be adequately trained to serve as replacements for officers now deferred to April 1 and for the period when they will represent practically the entire supply—after July 1, 1946. It must be remembered that it is essential to return to a peacetime basis at the earliest possible moment and anything less abrupt would only delay reaching that goal.

In the interest of adequate distribution of the available supply of veterans, it is expected that hospitals will not fill their house staff out of proportion to present quotas. Note that these veterans should be used first as replacements and present quotas for residents should not be exceeded until all deferred commissioned officers who have not been on active duty have been released from that particular hospital. This is not contrary to the policy of not counting veterans in quotas until they are sufficiently trained to be used as replacements.

It will not be necessary to submit Forms 218 for the continuation of interns for the period from April 1 to July 1, referred to in Paragraphs A and B, Section I, above. It will be presumed, however, that the junior residents referred to in Paragraph B, Section I, practically without exception, will not be requested for this period and will be released prior to but not later than April 1 and as soon as they can be satisfactorily re-

placed by officers discharged or separated from the service.

We can not emphasize too strongly the necessity of reconverting from the 9-9-9 Program as rapidly as possible and to the greatest extent possible, for the purpose of returning to the July to July twelve-month internship this coming year. The most available and safest supply of physicians to serve residencies will be these who have completed their military obligation to the Nation during the war and the duration of the emergency.

#### V. A. To Head Up Work on Prosthetic and Sensory Device Program

The Veterans Administration will take over on January 1, 1946, all of the development and research work being conducted on prosthetic and sensory devices (artificial limbs, hearing aids, dentures, etc.) by the Office of Scientific and Research Development, a wartime agency which is scheduled to go out of existence December 31. In addition, the Veterans Administration will assume on January 1, 1946, the Army's experimental work in these fields in connection with the OSRD and the National Academy of Sciences.

This means that the Veterans Administration will become the central Federal agency for all research and development work on prosthetic appliances so that all Government as well as outside agencies may benefit from the results of a unified program.

The Veterans Administration also has formulated plans for an immediate research and educational program to teach the disabled veteran to properly use artificial limbs or other prosthetic and sensory appliances as quickly as possible.

#### Award for Goiter Essay

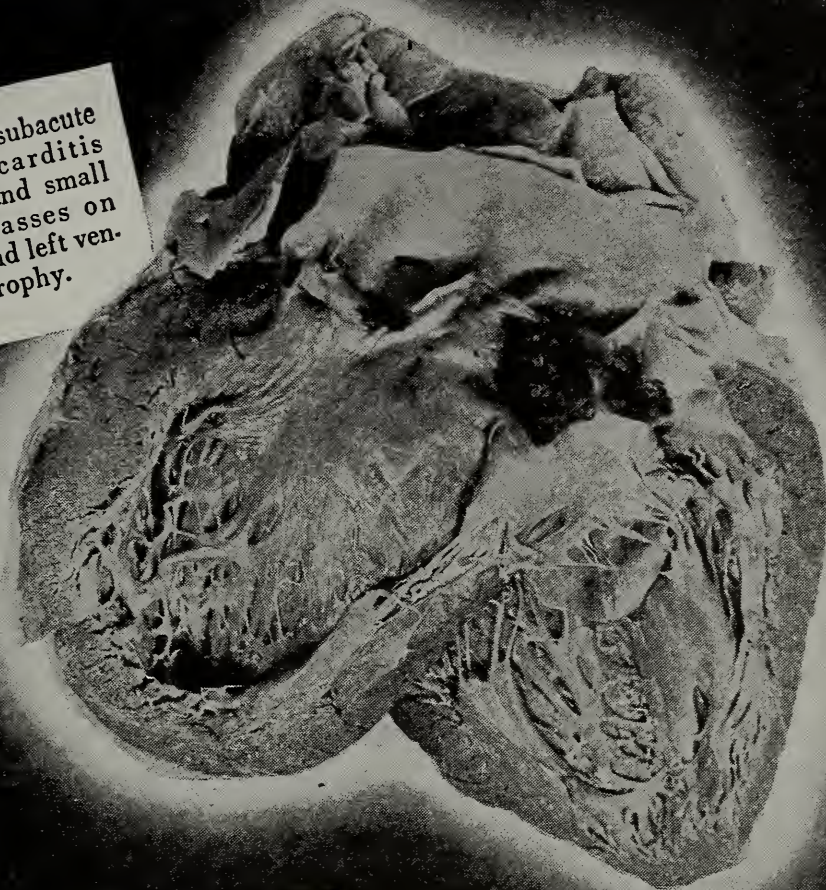
The American Association for the Study of Goiter again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Chicago, Illinois in April or May, 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia not later than February 20, 1946.

Portsmouth—Dr. James W. Fitch, Scioto County's oldest practicing physician, celebrated his 80th birthday recently. He has been in active practice for 52 years.



Typical heart of subacute bacterial endocarditis showing large and small thrombotic masses on aortic valves, and left ventricular hypertrophy.



**PENICILLIN**

## ... IN SUBACUTE BACTERIAL ENDOCARDITIS

Penicillin is the best agent available for the treatment of this devastating disease. Although in a few instances it may be desirable to use the continuous intravenous route, intramuscular injection is the one of choice. If best results are to be obtained 200,000 to 300,000 units should be given daily for three weeks or longer. (Keefer, C. S. et al.: New Dosage Forms of Penicillin, J. A. M. A. 128:1161, Aug. 18, 1945.)

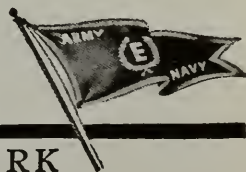
Bristol Penicillin, because of its low toxicity and freedom from pyrogens, as well as its absolute sterility and standard potency, provides dependable therapeutic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the *BRISTOL PENICILLIN DIGEST*. If you are not receiving *your copies* regularly, drop us a line.

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# In Our Opinion:

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## Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

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### JILT THE JITTERS, DOCTOR, AND START PITCHING!

Our hat is off to those 150 officers and committeemen of County Medical Societies and the State Association from all over the state who braved nasty weather to attend the Conference of County Society Presidents and Secretaries at the Deshler-Wallick Hotel, on Sunday, November 11.

Listening to some of the conversations during the recesses, we were impressed with these facts: Physicians are tired, physically and mentally. Some of the problems growing out of the war and looming large in the reconversion period have them confused and disturbed. The propaganda being disseminated by the up-lifters and do-gooders, much of it misleading, has made them angry.

The net result is that a lot of the docs are jittery and restless. Some of them are so upset that they want a change in everything without just knowing why. Some of them want to take a swing at everything and everybody; some want to curl up and hibernate.

All of them are partially right; partially wrong, in our opinion.

There is no sense in getting the jitters so badly that one loses his sense of values or his ability to act intelligently. There is no sense in wanting to change everything, slicing here and slicing there, without knowing why; where it will lead. There is no sense in becoming so pugnacious that one falls into the trap of becoming an habitual opposer, never taking affirmative action on anything.

The situation is not nearly as hopeless as a few think it is. The spirit and enthusiasm shown by the great majority at the November 11 meeting indicate that there is plenty of life left in the medical profession; plenty of ability; plenty of guts.

And, don't forget, also, that the medical profession has a potent organization—one which can pack a real punch—if every member will get in and do some packing. Many times the fellows who do little, if any, packing and pitching are the very ones who want to start a revolution or want to curl up and die, believing that everything's going to Hades in a basket anyway.

Straight thinking, with courage and initiative to back it, is what the medical profession needs—must have—in these days. It needs more members like the devoted and interested men and women who came to Columbus on November

11—not because they had to, but because they wanted to. They are the spark plugs. But, don't forget, they can't carry the whole load.

### TIME TO QUIT STALLING ON RELEASE OF PHYSICIANS

"Armed Forces to Make Bid for Services of Doctors" read a headline in the *Cincinnati Enquirer* over an article quoting from an address by Deputy Surgeon General of the Army George F. Lull before the Southern Medical Association Convention, in which General Lull talked about pay raises, educational opportunities, etc.—"inducements" the Army plans to offer members of the medical profession to remain in the Army Medical Corps.

With all due respect to everybody concerned, this gives us a snicker. And, when we reflect on the ring-around which has been given medical officers in the demobilization program, our blood pressure skyrockets.

What would have pleased us immensely would have been a statement that the War Department had abandoned the use of that simple but devastating phrase, "except those in the medical department", in its directives regarding the lowering of points or the release of officers.

Since we don't want to play favorites, we think the Navy also has been about as speedy as a snail in getting its physicians back to civilian practice.

During the war, the civilian population and the medical profession on the home front gave their complete cooperation to the needs and demands of the military forces. When the military said they needed more doctors, everybody said O.K.—occasionally with their tongue in their cheek, to be sure.

The picture has changed. Recently somebody bragged about the 3,000,000 veterans having been demobilized. The shooting is over. Many casualties have been released from the hospitals. Yet, the comparative number of medical officers discharged has been pathetically small. Letters from physicians still overseas—many of them high-point men, or men of the upper age group—indicate that they have had little or nothing to do since V-E Day; are actually outnumbering their patients; are being assigned to duties which could be done by lay clerks, etc.

Plenty of promises have been made by the Army and Navy but these have been followed with little—disgustingly little—action.

Protests of the medical profession back home



# the obligations of victory

Victory, too, imposes obligations. The fruits of our efforts and the sacrifices of the past four years will be determined by our actions today.

There is much to be done if we are in some small measure to repay those who fought for us.

For those who died there are families to care for; those who were hurt must be brought back to health; and even those who returned without physical injury need to be helped back to a normal peacetime existence.

"... to the great task remaining before us."

## BUY VICTORY BONDS

They finished their job; let's finish ours.



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# Upjohn



KALAMAZOO 99, MICHIGAN • FINE PHARMACEUTICALS SINCE 1886

have been sent to Washington officials. The Council of this Association sent a strongly worded statement to the Capitol last August. Ohio's Congressmen have been putting on the heat. More men are being discharged but to date, these results have had little material effect.

Therefore, from now on we're going to start swinging. We're going to suggest to our Congressmen (and suggest that you do so also) that they swing a little harder. And, if necessary, we're going to submit the case to the people themselves. They, too, are becoming increasingly dissatisfied with the whole blooming demobilization program, including the release of doctors and everyone else.

Sure, we favor enough medical personnel for American servicemen in each theater of operation and in general hospitals; but, no more, no less. There is too much surplus in medical talent overseas. It should be brought home at once. Let the Army and Navy revise their tables of organization downward immediately. In other words, it's time for them to quit stalling and act.

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#### **SIDELIGHTS ON A.A.P.S. CAMPAIGN IN OHIO**

Circulars being distributed in Ohio by sponsors of the Association of American Physicians and Surgeons, Inc., of Lake County, Indiana, leave the inference that the organization has received the endorsement of the Ohio State Medical Association. Just a minor mistake—the State Association has not endorsed it; in fact, The Council in a statement adopted last January 14 said, in effect, that it believes this and similar organizations entirely unnecessary.

Also, we note that reference has been made to endorsement of the A.A.P.S. by a number of local medical societies, including the Columbus Academy of Medicine. We have no figures on the votes cast by all the societies, but we have been reliably informed that the vote at the meeting of the Columbus Academy at which the "endorsement" was voiced was 16 affirmative votes and 10 negative votes. The membership of the Columbus Academy of Medicine is 609—even counting out men in the service, around 400. The tail wags the dog, it seems.

To quote one pertinent comment from The Council's statement, referred to above: "Members of the medical profession, by concentrating their efforts on improving and strengthening their own national, state and local medical societies, are more likely to achieve the goals of unity of purpose and effective action than by scattering their interest and efforts among the several independent organizations, now asking for their support, regardless of how worthy the purposes and motives of such organizations may be."

#### **TAX CUT NOT EFFECTIVE UNTIL 1946**

Just in case you are counting on cutting a melon prematurely, remember that the new income tax bill which reduces future income tax rates will not affect 1945 income.

The present law will apply to 1945 income, the final payment of taxes falling due next March 15. The modified law will not benefit you until 1946.

Always someone taking the joy out of life, isn't there?

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#### **BETTER BEWARE OF THOSE PROFESSIONAL BLINDERS**

Ben Ames Williams, the author, in a lecture at Harvard Medical School recently took a one-two punch at the medical specialists who "wear professional blinders". Williams described the most successful specialist as the "one who supplements his professional competence with what salesmen call a good approach". He suggested that the specialist should investigate what kind of a man his new patient is, just as a reporter sent to interview a celebrity always tries to learn in advance something about him.

If we gather what Ben was driving at, he was attempting to debunk that holier-than-thou pose and mechanical-man approach which are so liable to creep into the practice of a physician after success is attained unless he keeps reminding himself that in the end patients are human beings, not mice and guinea pigs.

Since Williams is no novice at the job of public relations, it won't harm the doctor in taking a tip from him about how to make a "good approach".

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#### **WHO IS ENCOURAGING WHAT AND HOW?**

In an editorial in its November 10 issue, *The Journal of the American Medical Association* brands the proposed Maternal and Child Care Act of 1945 (the Pepper Bill, Senate Bill 1318) "a hastily conceived, potentially dangerous piece of legislation", adding that the objectives it seeks to reach are desirable but that the proposed measure "would not obtain those objectives and would destroy much that has already been done toward their accomplishment".

Commenting on the same proposal, the Washington Letter of the United Public Health League, notes that there is a great deal of propaganda being sent out by the Children's Bureau to parents, women's clubs, P.T.A.'s and such.

Referring to the Pepper Bill as "an easy approach to socialized medicine", the health league's letter marvels that a Federal Bureau "consisting of eleven women and two men, only three of whom are doctors, can gain such impetus during



# Dependable Nourishment



The well nourished baby is more resistant to the common ills of infancy. Moreover it is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. Similac-fed infants are notably well nourished; for Similac provides breast milk proportions of fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle fed infant — *from birth until weaning.*



A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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this period as to come so close to gaining control of an economic situation in the U. S.”.

The observation is made that perhaps the bureau has been encouraged by the unusually large number of physicians who apparently have not been too adverse to accepting cases and fees under the E.M.I.C. program—the “emergency” (sic) program for servicemen’s families.

What do you think?

### LET’S GIVE THE FUNERAL DIRECTOR A BREAK

In a communication to the *Toledo Academy of Medicine Bulletin*, the Northwestern Ohio Funeral Directors’ Association calls to the attention of the medical profession that funeral directors have been experiencing considerable difficulty in getting physicians to sign death certificates promptly. Instances were cited where funeral directors, in an effort to be helpful, have taken certificates to the physician’s office where they were told to return later or were asked to cool their heels from two to three hours.

It is just as much the duty of the physician to make out and sign his part of the death certificate as it is the duty of the funeral director to execute his portion of the blank.

Even though the doctor these days is pestered continuously with blank-stickers, there is no valid reason why there should not be cooperation between the doctor and the funeral director. It’s all a matter of proper timing.

### PROBLEM OF THE AGED AN INCREASING ONE

“How can existing welfare and health programs be adapted and new programs be developed to meet the needs of an ‘aging’ population? asks the *Cleveland Division of Health Bulletin*.

That’s not an idle inquiry. It’s a question which the medical profession must face now or later.

It is estimated that by 1950, 7.6 per cent of the inhabitants of Cuyahoga County will be over 65 years of age. Medicine, including the specialty of public health, has conquered diseases that used to kill thousands of people in infancy, youth and middle age. Now the emphasis must be focused in a new direction—toward the aged.

What to do for them to keep them alert and happy? How to advise them? What are their needs; the opportunities for them to continue vocational and social activities? How to instill in them alert mental habits? These are some of the baffling questions pertaining to the aged which confront many physicians and will face them to an increasing degree in the future.

Medicine and social welfare must unite in attempting to find the answers.

### MORE AND MORE FOR LESS AND LESS = ZERO

Reliable observers report that the Rhode Island Sickness Insurance Fund (the only state system in existence) will be insolvent in 1947 if present disbursements and declining contributions continue. A million dollar deficit this year is predicted.

Unless we’re poor guessers, the crafty hand of politics has upset the best laid plans in “Little Rhody”. Give more and more, for less and less never ceases to be a popular slogan for the office-holder to follow. But, it doesn’t add up too well from an actuarial point of view. So then the tax mill has to start in grinding again.

Mr. Truman and Messrs. Wagner, Murray and Dingell, please copy.

### NOTHING LIKE HAVING IT IN WRITING

“Nothing like having it in writing” says the Texas State Medical Society, in commenting on letters which were written to Texas Congressmen asking them to state in black and white their views of the Wagner-Murray-Dingell proposals for a Federal sickness insurance system.

Gentlemen, we can’t have those Texas Rangers beating us to the draw. Get out your trusty pen or typewriter and dash off a letter to **your Congressman**, asking him to tell you in plain English what he thinks about the new Truman-Wagner-Murray-Dingell set-up.

And, if we may be bold enough to suggest, if you aren’t satisfied with his reply, tell him in unvarnished Ohio lingo that you aren’t and why. ’Tis said the politician keeps his ear to the ground. So make’r rumble.

### YOU CAN’T WIN UNLESS YOU PUT UP THE ANTE

Last month in these columns we opined that local communities must get essential services by paying their own way or take the consequences—no services or losing control to state or Federal agencies which step in to do the job.

Lo and behold a good example of what we were driving at is dropped on the doorstep!

State Director of Health Heering has notified the City of Columbus that it must increase its share of funds being used for a venereal control program next year or run the risk of losing state-Federal aid. The city is now putting up \$10,000; the state and Federal governments, \$28,000. Dr. Heering, being an advocate of local responsibility, is willing to give Columbus a chance. If the warning goes unheeded, he can do one of two things, either of which will adversely affect the city: (1) He can withdraw the state-Federal support or (2) he can under broad gen-





With children . . . "...the benzedrine inhaler can be satisfactorily employed for young children for the relief of obstructive symptoms in the nasopharynx due either to infection or to allergic edema. No untoward symptoms were noted from the use of the inhaler."

Vollmer, E. S.: Use of the Benzedrine Inhaler for Children, Arch. Otolaryng. 26:91.

Benzedrine Inhaler a better means of nasal medication



In a recent survey of pediatricians, 77% were found to use Benzedrine Inhaler; N.N.R., in their practice.

Children accept Benzedrine Inhaler therapy willingly, and show none of the hostility which so often complicates the administration of drops, tampons, or sprays. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Philadelphia, Pa.

eral health powers foot the entire bill and take over supervision of the program. Doubtless, he does not wish to do either but in the final analysis the answer must come from the City of Columbus.

You don't get something for nothing. The sooner every community learns that—in public health services as in other activities—the better off they will be.

### TELL 'EM WHAT YOU'RE FOR—AND NOW

When the recently adopted 14-Point Platform of the American Medical Association was announced, it was pointed out that it would not be worth too much unless the suggestions contained therein were to be followed up by local pronouncements and action—with emphasis on "action".

What has your local society done on this matter?

And, when your society does act, don't forget that affirmative action in the long run always serves a more useful purpose. Tell your community through your platform what you stand for; enumerate those items for community health which you support and for which you will fight. In other words, tell the people what you are opposed to by naming the things which you favor and believe to be for the best interests of your community.

That's good public relations; that's constructive thinking and action.

### Name New Assistant Medical Dean at Western Reserve

Appointment of Dr. John L. Caughey, Jr., as assistant dean of the School of Medicine of Western Reserve University has been approved by the trustees. Dr. Caughey, who will also do research work in the department of medicine at the School of Medicine, was an associate in medicine at Columbia University from 1941 until this year and worked with Dr. George Draper at Presbyterian Hospital in New York in the study of human constitution in relation to disease.

Born in Rochester, N. Y., May 30, 1904, Dr. Caughey received his Bachelor of Arts degree from Harvard University in 1925, his M.D. from Harvard in 1930, and the degree of Doctor of Medical Science from Columbia in 1935.

Cincinnati—Dr. Carl A. Wilzbach, health commissioner of Cincinnati, and Dr. K. L. Minstead, chief of the Food and Drug Administration of that area, pointed out the dangers of self-diagnosis and self-medication at the October meeting of the Consumer Conference.

Dayton—Dr. Curtiss M. Ginn retired recently after 50 years in the practice of medicine.

## News Notes

Barberton—Dr. George R. Wellwood is the new president of the Kiwanis Club.

Cincinnati—Dr. Carl A. Wilzbach, health commissioner of Cincinnati, spoke on "Major Public Health Problems" at a meeting of the Wilmington Rotary Club.

Cleveland—The Cleveland Clinic Foundation has announced a \$2,750,000 expansion program which will increase the present capacity of its hospital from 250 to 430 beds.

Columbus—Dr. Charles A. Doan, dean, Ohio State University College of Medicine, spoke on the University's proposed \$5,000,000 Medical Center at a recent meeting of the Kiwanis Club.

Eaton—Dr. Carle W. Beane, Preble County health commissioner, spoke on "Tuberculosis" at a meeting of the Rotary Club.

Elyria—Dr. Gordon A. Smith, who served 32 months as a captain in the Army Medical Corps, including a year in England, has been appointed acting city health commissioner. He returned to civilian practice in April.

Gilboa—Dr. Chas. J. Ray has entered his 51st year of continuous practice in this Putnam County community.

Ironton—Dr. Heber Johnson gave a talk on "Penicillin" at a meeting of the Russell Rotary Club.

Logan—Dr. John T. Gibbons, Celina, who returned recently from service overseas in the Medical Corps of the U.S. Army, has purchased the 40-bed Cherrington Hospital. According to the press, he will continue to make his home in Celina for the present.

Mechanicsburg—Dr. A. B. Ream has returned here to resume private practice after four years as health commissioner of Clermont County.

Middletown—"The History of Medicine" was reviewed by Dr. R. A. Hill at a meeting of the Ramblers Club.

Painesville—Dr. Frank F. Tallman, Columbus, State Commissioner of Mental Diseases, spoke on "Emotions and Education", at the opening of the Mental Hygiene Conference of the local public schools.

Port Clinton—Dr. George A. Poe is the new health commissioner of Ottawa County.

Washington C. H.—Dr. Carl A. Wilzbach, health commissioner of Cincinnati, spoke on "Problems of Public Health" at a meeting of the Rotary Club.

Youngstown—County commissioners and trustees of the Mahoning County Tuberculosis Sanatorium have announced plans for a \$225,000 building and remodeling program.





***"you sure sound  
good to me, mister"...***

—A typical compliment to "Biolac Babies"—and, at the same time, a reflection of the physician's good judgment.

The soft-curd characteristics of Biolac assure ease of digestion. Adjusted milk fat content facilitates digestion and assimilation, with greater freedom from fat upsets; ample lactose assures soft, natural stool formation; and a high protein level contributes to optimal growth and health.

Since Biolac supplies adequate potencies of Vitamins A, B<sub>1</sub>, B<sub>2</sub>, and D, as well as iron, the need for time-consuming calculations of extra formula ingredients is eliminated. Indeed, Biolac (supplemented with vitamin C) provides *completely* for the nutritional requirements of the infant partially or entirely deprived of human milk.

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quickly prepared. 1 fl.  
oz. Biolac to 1½ fl. oz.  
water per pound of  
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# In Memoriam

Waite Adair, M.D., Lorain; Ohio State University College of Medicine, 1911; aged 60; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Nov. 3. Dr. Adair retired about a year ago, after having practiced in Lorain for over 30 years. He was a former president of the Lorain County Medical Society and was a delegate in 1929, 1942 and 1943. Dr. Adair served as a medical officer in World War I. He was a member of the Eagles, Masonic Order, American Legion and the Congregational Church. Surviving are his widow; three sons, including Dr. Donald R. Adair, an intern at the Cleveland City Hospital; three brothers, one of whom is Dr. Valloyd Adair, Lorain.

George Anderson, M.D., Xenia; College of Physicians and Surgeons, Baltimore, Md., 1891; aged 78; died Oct. 19. Dr. Anderson first practiced in Lumberton, moving to Alpha in 1893. He practiced there until ill health forced his retirement about three and one-half years ago. A son and a daughter survive.

Dorsey Wayland Fellers, M.D., Bloomville; Ohio Medical University, Columbus, 1902; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died Oct. 28. Formerly health commissioner of Seneca County, Dr. Fellers practiced in Bloomville for over 40 years. He was a captain in the Medical Corps during World War I, serving 11 months at Base Hospital No. 3, Bordeaux, France. Dr. Fellers was widely active in community affairs. He was a member of the Evangelical Church, Masonic Order, Knights of Pythias, and the American Legion. Surviving are his widow and a sister.

Albert Dabney Frost, M.D., Columbus; University of Pittsburgh School of Medicine, 1919; aged 56; member of the Ohio State Medical Association; Fellow of the American Medical Association; member of the American Academy of Ophthalmology and Otolaryngology, American Ophthalmological Society, Association for Research in Ophthalmology; Diplomate, American Board of Ophthalmology; died Nov. 15. Professor of ophthalmology at Ohio State University College of Medicine, Dr. Frost was nationally known in his field. He had practiced in Columbus since 1922. Dr. Frost had addressed many local, state and national medical groups on ophthalmological subjects. He was killed in an automobile accident in Virginia while returning from a meeting of the American Ophthalmological Society at Hot Springs. Dr. Frost was a member of the Masonic Order, Sigma Chi and

Phi Rho Sigma. His widow, a daughter, two sons, a sister and a brother, Dr. Ellis Frost, Pittsburgh, survive.

Alice Alloway Hand, M.D., Cleveland; Western Reserve University School of Medicine, 1944; aged 26; died Oct. 31. Dr. Hand completed her internship at Metropolitan Hospital, New York in July. Surviving are her parents, her grandmother, an aunt and an uncle.

Fred Warfield Lane, M.D., Cambridge; University of Pennsylvania School of Medicine, 1893; aged 73; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 11. Dr. Lane first opened an office in Barnesville, and after a short time, moved to Cambridge, where he was in active practice for over 50 years. A former president of the Guernsey County Medical Society, Dr. Lane had also been delegate and legislative committeeman. He was a major and regimental surgeon of the 46th Infantry during World War I. Dr. Lane was a member of the Presbyterian Church, Masonic Order and a past commander of the local American Legion. His widow, a daughter, a sister and a brother survive.

Frank T. Marr, M.D., Chillicothe; College of Physicians and Surgeons, Baltimore, Md., 1901; aged 68; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 27. A former president of the Ross County Medical Society, Dr. Marr practiced in Chillicothe for 44 years. He was a member of the Presbyterian Church, Masonic Order and the Elks Lodge. His widow, a son, a sister and a brother survive.

William Eugene Ranz, M.D., Youngstown; Miami Medical College, Cincinnati, 1899; aged 72; member of the Ohio State Medical Association and Fellow of the American College of Surgeons; died Oct. 20, at McAllen, Texas, to which he retired about five years ago. Dr. Ranz practiced in Youngstown for 40 years. During World War I, he was major in the Medical Corps. Dr. Ranz was active in community affairs, having been president of the Mahoning Motor Club, a member of the Board of Education and one of the organizers of St. Elizabeth Hospital. He was a member of the Odd Fellows Lodge and the Masonic Order. Surviving are his widow, a daughter, two sons, a sister, and two brothers, one of whom is Dr. M. Ranz, Youngstown.

Robert Ellsworth Riley, M.D., Celina; Rush Medical College, Chicago, 1893; aged 82; former member of the Ohio State Medical Association





FOURTH IN A SERIES OF CHALLENGES TO MEDICINE'S

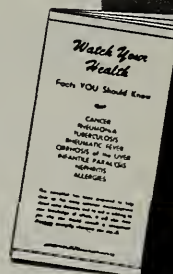
## Achievements For Tomorrow



**POLIOMYELITIS** is a dreaded disease. The virus has been isolated and many of its habits are known. But — we must find out why it strikes down some, yet fails to make others sick, and we must discover some method of immunizing susceptible persons against the insidious polio virus.

Until research leads us to the solution, the public should continue to be educated — given the facts about polio so they will not become panicky during an epidemic, but will know how to employ the best preventive measures.

In the pamphlet "Watch Your Health" we have given such information on poliomyelitis—one of the seven serious diseases discussed. Copies for distribution to your patients are available on request.

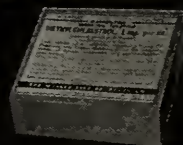
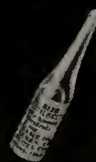
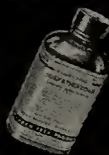


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and the American Medical Association; died Oct. 25. Dr. Riley practiced in Celina for nearly 50 years. He represented the Shelby County Medical Society as a delegate to the Ohio State Medical Association in 1931-32-33-43. Dr. Riley was a member of the Methodist Church, Masonic Order and the Woodmen of the World. Two sons, a sister and a brother survive.

**James Melburn Ruckman, M.D., LaRue;** Starling Medical College, Columbus, 1900; aged 73; member of the Ohio State Medical Association and the American Medical Association; died Oct. 25. Dr. Ruckman began practice in Jenera, Hancock County, locating in LaRue in 1918. His practice extended into Marion, Union, Harding and Wyandot Counties. Dr. Ruckman was a member of the LaRue Board of Education from 1921 to 1942 and also was a member of the Marion County Board of Education for a period ending in 1943. He had been coroner of Hancock County for one term and served part of term as coroner of Marion County, resigning in 1941. Dr. Ruckman was a member of the Masonic Order and the Methodist Church. Surviving are his widow, two daughters and three sons.

**Levi Alberta Ruhl, M.D., Covington;** Jefferson Medical College, Philadelphia, 1905; aged 68; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 19. Dr. Ruhl practiced in Covington for 40 years. He was a member of the Presbyterian Church, Masonic Order and the Jr. O.U.A.M. His widow, a son and a sister survive.

**John G. Seiter, M.D., Marion;** Cleveland University of Medicine and Surgery, 1881; aged 93; died Oct. 23. Dr. Seiter had been retired for many years. He was mayor of Marion from 1910 to 1912. Surviving are his widow, two daughters, two sons and a brother.

**John Gill Shimmon, M.D., Cleveland;** University of Wooster, Medical Department, 1912; aged 61; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 23. Dr. Shimmon practiced in Cleveland for over 40 years, and during that time resided in Willoughby. Active in civic affairs there, he served on the Board of Education for 18 years, was a director of Andrews School for Girls, and a member of the official board of the Methodist Church. Other interests included the Boy Scouts and gardening. Dr. Shimmon had been president of the Northeastern Ohio Boy Scouts Conference, receiving the Silver Beaver award for his services. He was president of the Cleveland Orchid Society and a member of the Cleveland Business Men's Garden Society. Surviving are his widow, two daughters, a sister and three brothers.

**Horace Frederic Tangeman, M.D., Cincinnati;** University of Cincinnati College of Medicine, 1912; aged 57; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology; Diplomate, American Board of Otolaryngology; died Oct. 11. Dr. Tangeman practiced in Cincinnati for 33 years. He was a major in the Medical Corps during World War I. His widow and a sister survive.

**Chauncey Albert Walker, M.D., Louisville;** Ohio Medical University, Columbus, 1898; aged 72; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 28. One of Stark County's best known physicians, Dr. Walker practiced in Louisville for 47 years. He was a member of the Reformed Church and the Masonic Order. Surviving are his widow and a daughter.

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### Union District Medical Meeting

The 158th semi-annual meeting of the Union District Medical Association was held in conjunction with the Butler County Medical Society, October 25, at the Y.W.C.A., Hamilton. After a turkey dinner, the following program was presented: "Mechanics of Orthopedics", Wm. Sims, manager, Brace Shop, Cincinnati General Hospital; "Aspects of Emergency Military Surgery", Dr. R. D. Mansfield, Greenhills; "Military Surgery", Dr. Malcolm Cook, Hamilton; "Newer Developments in the Treatment of Cancer", Dr. Esther Marting Fabing, Tumor Clinic, Chicago, Ill. Officers of the Association are: Dr. Clyde I. Stafford, president, Oxford; Dr. Fred W. Brosius, Middletown, vice-president; Dr. E. M. Glaser, Brookville, Ind., secretary-treasurer.

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### Receiving Hospital Dedicated

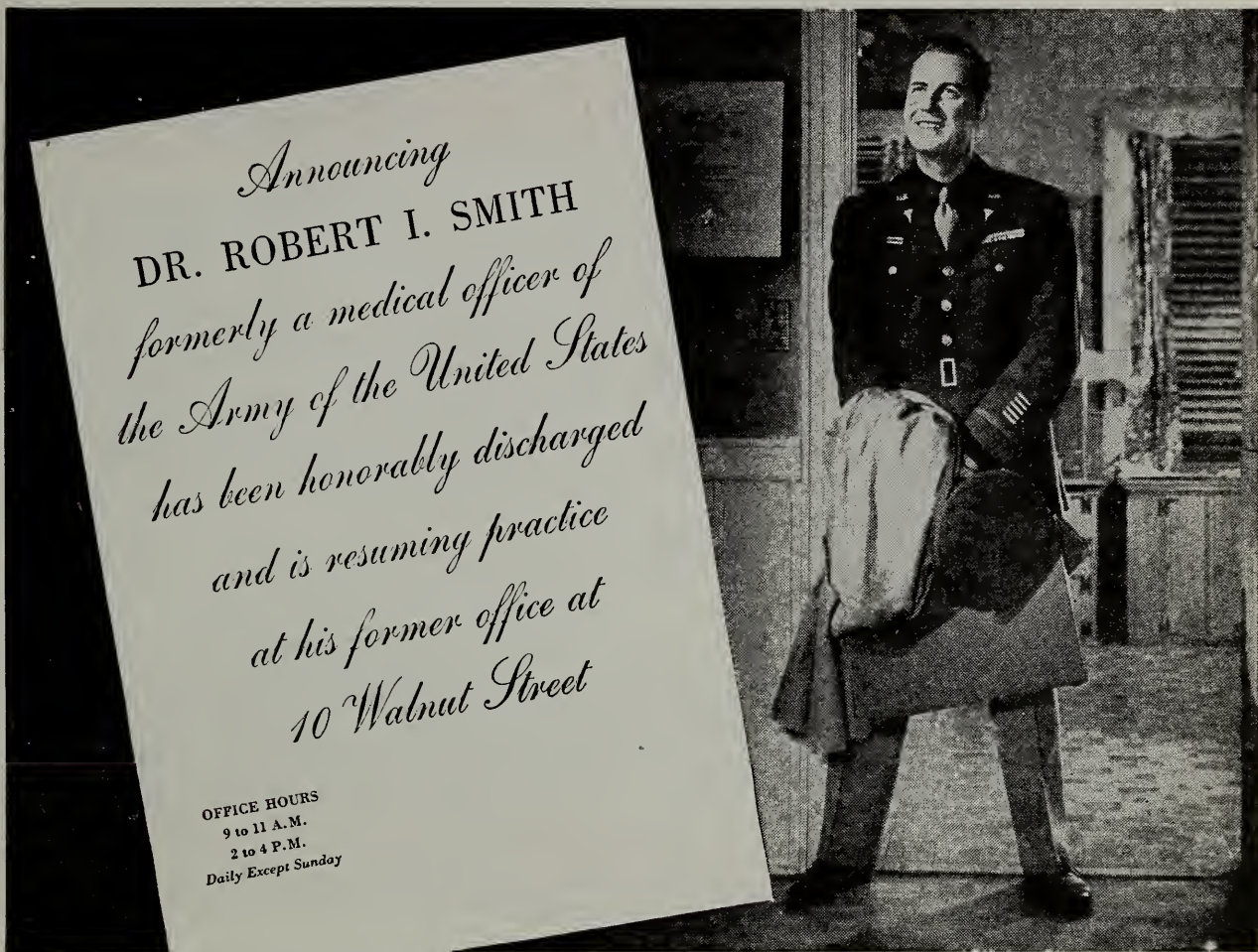
Ohio's first receiving hospital for mental patients, the first of five such hospitals for which the State Legislature made appropriations in the \$23,000,000 expansion program of the State Welfare Department, was opened at Youngstown on Nov. 20. The 85-bed hospital, which was the abandoned Youngstown municipal hospital for contagious diseases, will serve 14 Northeastern Ohio counties. Others are to be located at Cleveland, Akron, Athens and Columbus. Dedication speeches were made by Frazier Reams, State Welfare Director, and Dr. Frank F. Tallman, State Commissioner of Mental Diseases.

Middletown—"Health and the Job" was the topic of an address made by Dr. Mabel E. Gardner, at the annual meeting of District 2, Ohio Federation of Business and Professional Women's Clubs.



*Announcing*  
**DR. ROBERT I. SMITH**  
*formerly a medical officer of  
 the Army of the United States  
 has been honorably discharged  
 and is resuming practice  
 at his former office at  
 10 Walnut Street*

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 Daily Except Sunday



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The medical men in the war will be the subject of novels, plays, and movies for years to come. But words, pictures . . . statistics, revealing as they are . . . won't begin to tell the whole story of the magnificent work you did. Nor will words be adequate to express fully the appreciation and thanks of your fellow men.

The makers of Camel cigarettes join with millions of others in saying, "Well done, Doctor" and "Welcome home!"

**CAMELS** *Costlier*  
*Tobaccos*

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# Activities of County Societies

## First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

### HAMILTON

The Cincinnati Academy of Medicine presented the following programs during November:

Nov. 6—Joint Meeting with the Diabetes Council. "Spontaneous Hypoglycemia: Etiology, Differential Diagnosis and Treatment", Dr. J. W. Conn, assistant professor of medicine, University of Michigan Medical School, Ann Arbor.

Nov. 20—Joint Meeting with the Cancer Control Council. "The Extension of Radical Surgery in the Treatment of Cancer", Dr. George T. Pack, assistant professor of clinical surgery, Cornell University Medical College, New York.—Bulletin.

## Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

### MIAMI

Two sound movies in color, "Otitis Media in Pediatrics", and "A Clinic on Acute Mastoiditis", were shown at a meeting of the Miami County Medical Society, Nov. 2, at Memorial Hospital, Piqua.—Geo. A. Woodhouse, M.D., secretary.

## Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

### AUGLAIZE

Dr. G. A. Edwards, Van Wert, spoke on "Cancer of the Throat", at a meeting of the Auglaize County Medical Society, Oct. 11, at Wapakoneta.—News clipping.

## Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

### LUCAS

The Toledo Academy of Medicine presented the following programs during November.

Nov. 9—Section of Pathology, Experimental Medicine and Bacteriology. Symposium of the Legal Relationship to Medical Practice. "Legal Aspects of Industrial Medicine", Wm. J. Higley, attorney-at-law; "Legal Aspects of Personal Injuries", Wayne E. Stichter, General Counsel, Ohio Medical Indemnity, Inc.; "Criminal Aspects in Relationship to Medical Practice", Joel S. Rhinefort, prosecuting attorney, Lucas County.

Nov. 16—Medical Section. "Typhus—Observations on Epidemic Typhus Fever in Europe", Dr. Andrew Extejt and Dr. Walter Johnson.—Bulletin.

## Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

### CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during November:

Nov. 2—Clinical and Pathological Section. "The Early Development of Syphilitic Aortitis", by Dr. Frank S. Houser and Dr. Edward M. Kline; "Pituitary Myxedema, Case Report", Dr. E. E. Beard; "Modern Concepts in Anesthesia", Dr. B. B. Sankey; "Congenital Arteriosclerosis with Myocardial Infarction", Dr. Rafael Dominguez.

Nov. 9—Experimental Medicine Section and Section of the Society for Experimental Biology and Medicine. "A Myeloid Metaplasia Factor from Human Urine; Biological Effects; Studies of Chemical and Physical Properties", Drs. Robert W. Heinle, Hans Hirschmann and Joseph T. Wearn, Department of Medicine, Western Reserve University School of Medicine; "An Evaluation of Five Years' Experience with Radio-active Phosphorus in the Treatment of Leukemia and Other Diseases", Drs. Charles A. Doan, Claude Starr Wright and Joseph H. Geyer, Department of Medicine, Ohio State University College of Medicine.

Nov. 14—Industrial Medicine and Orthopedic Section. "Lumbar Radiculitis", Dr. Maxwell Harbin; "Congenital Pseudo-arthritis of Tibia; An Operation for Metatarsus Varus", Dr. Clarence Heyman; "Scoliosis with Paraplegia; Two Cases of Ewing's Tumor", Dr. John A. Murphy; "Eosinophilic Granuloma", Dr. Carroll Dundon and Dr. Thomas Laipply.

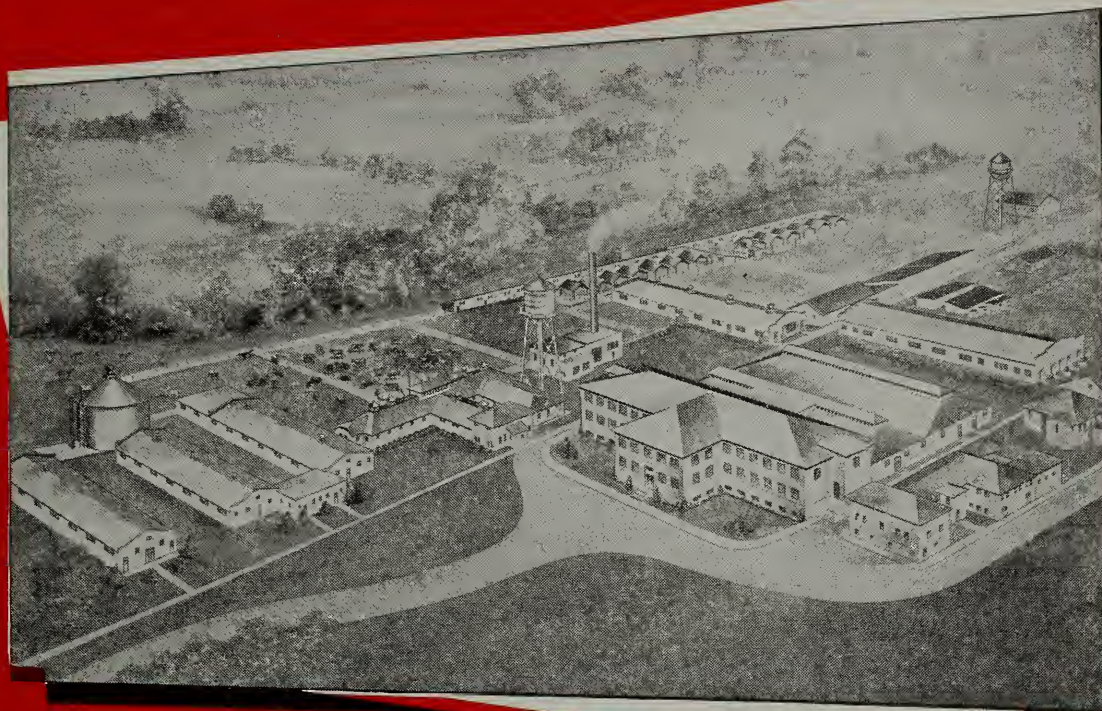
Nov. 16—Fifth Annual Lower Lecture. "Hormonal and Dietary Factors in the Pancreas", Dr. Charles S. Best, professor of physiology, University of Toronto.

Nov. 21—Pediatric Section. "Albers-Schönberg Disease", Dr. Emilia M. Nitsch; "Congenital Lues and Hydronephrosis", Dr. Wilva M. McIlmoyle; "Brain Abscess", Dr. Russell A. Morissette; "Tetanus, with Recovery", Dr. Margaret Dowell; "Repeated Attacks of Mumps", Dr. Otto L. Goehle; "Three Diphtheria Deaths", Dr. Morris Schaeffer; "Undiagnosed Intestinal Condition", Dr. Charles W. Burhans; "Congenital Anomaly of the Urinary Tract", Dr. John H. Davis; "Presentation of X-ray Films", Dr. James D. Pilcher; "Foreign Body Diagnosed As Diphtheria", Dr. John A. Toomey.—Bulletin.

### ASHTABULA

At a meeting of the Ashtabula County Medical Society, Oct. 9, at Ashtabula, Capt. A. M. Mills, recently returned from service in the





# Expanding —

**The rapidly increasing demand for Pitman-Moore Biologicals has compelled us to launch an extensive new building program.**

With the completion of a large addition to the main building of our Biological Laboratories, increased capacity has been provided for vaccine production, serum processing and control testing.

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animals essential to safeguarding the potency, purity and safety of finished products.

Pitman-Moore look forward to an ever expanding program of service to the medical profession through the medium of the Biological Laboratories at Zionsville, Indiana, as well as the Pharmaceutical and Research Laboratories at Indianapolis.

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Medical Corps, spoke on "Military Medicine and Surgery", and Dr. Edward W. Shannon, Cleveland, discussed "Surgical Treatment of Hypertension".—News clipping.

## Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

### MAHONING

Dr. Wm. F. Rienhoff, Jr., of Johns Hopkins University School of Medicine, Baltimore, Md., spoke on "The Present Status of the Treatment of Malignant Tumors of the Lungs", at a meeting of the Mahoning County Medical Society, Nov. 20, at Youngstown. Dr. R. E. S. Young, Columbus, discussed "Principles and Objectives of the A.A.P.S.", at a meeting of the society, Nov. 27.—Bulletin.

### PORTAGE

Dr. Joseph M. Hayman, Cleveland, associate professor of medicine, Western Reserve University, formerly chief of medical service of the Lakeside Unit in Australia and New Guinea and later chief of medical service, Moore General Hospital, Swannanoa, N. C., was the guest speaker at a meeting of the Portage County Medical Society, Nov. 8, at Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

### STARK

The annual Postgraduate Day of the Stark County Medical Society held at Onesto Hotel, Canton, Oct. 17, was well attended. An exceptionally fine program was presented by Drs. Marion A. Blankenhorn, Max M. Zinniger and William A. Altemeier of the Faculty of the University of Cincinnati College of Medicine. Many favorable comments have been received about the meeting and the dinner.

At the society's meeting on Nov. 14, Dr. Andrew Marchetti, New York, presented an excellent paper, illustrated by beautiful colored slides on "The Early Diagnosis of Cancer of the Female Generative Tract".—L. E. Anderson, M.D., secretary.

### SUMMIT

Dr. William N. Taylor, professor of urology, Ohio State University College of Medicine, spoke on "Critical Review of Prostatic Resection", at a meeting of the Summit County Medical Society, Nov. 6, at the Nurses' Home, Akron City Hospital.—Bulletin.

## Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

### GUERNSEY

Two of the members recently returned from military service were speakers at recent meetings of the Guernsey County Medical Society. Dr. W. L. Denny told of his hospital experiences in England and France, at a meeting at Cambridge on Oct. 15, and Dr. E. E. Conaway showed pic-

tures and spoke of his work in the South Pacific at a meeting on Nov. 15. Dr. George T. Pack, New York City, a native of Cambridge, related his observations of socialized medicine in Chile, Mexico, Russia and other countries, at a meeting of the society on Nov. 1.—M. S. Lawrence, M.D., secretary.

### MUSKINGUM

Dr. Louis Mark, Columbus, spoke on "Pulmonary Diseases, and Their Modern Treatment", at a meeting of the Muskingum County Academy of Medicine, Nov. 7, at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secretary.

## Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

### HOCKING

Members of the Hocking County Medical Society and physicians from neighboring communities, were guests of Dr. John Gibbons, Celina, new owner of the former Cherrington Hospital, at a get-acquainted dinner, Oct. 11, at the American Legion clubrooms, Logan.—News clipping.

## Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

### FAYETTE

At a meeting of the Fayette County Medical Society, Oct. 11, at Washington C. H., a schedule was worked out for a year by which one physician will be available, either at his office or residence, for emergency calls on Sundays and Wednesdays.—News clipping.

### FRANKLIN

The Columbus Academy of Medicine presented the following programs during November:

Nov. 5—"Fungous Infections of the Skin", Dr. Burton Barney, Dr. Eldred Heisel and Dr. Louis Praver, with discussion by Dr. Joseph Shepard.

Nov. 19—"Current Concept of Pyelonephritis", Dr. Harry L. Reinhart, with discussion by Dr. Roswell Fidler.—Bulletin.

## Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

### LORAIN

A memorial address for the late Dr. Waite Adair was given by Dr. Charles Meek at a meeting of the Lorain County Medical Society, Nov. 13, at Castle-on-the-Lake, Lorain. Dr. Sidney Stone, Cleveland, spoke on "Perineal Injuries Due to Childbirth".—L. H. Trufant, M.D., secretary.

### WAYNE

"Practical Application of the RH Blood Factor", was the topic discussed by Dr. Edward Goodfit, Cleveland, at a meeting of the Wayne County Medical Society, Oct. 24, at the Board of Health offices, Wooster.—News clipping.



# Why do Tom, Dick and Harry need Vitamin D?



Growing children require vitamin D mainly to prevent rickets. They also need vitamin D, though to a lesser degree, to insure optimal development of muscles and other soft

tissues containing considerable amounts of phosphorus . . . Milk is the logical menstruum for administering vitamin D to growing children, as well as to infants, pregnant

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## WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)  
Chairman, Publicity Committee

### STATE CONFERENCE, OCTOBER 24-25

The Woman's Auxiliary to the Ohio State Medical Association held a one-day conference for county presidents and presidents-elect, preceding the regular Fall meeting of the Board of Directors, at the Deshler-Wallick Hotel, Columbus, October 24 and 25.

Mrs. Roswell W. Fidler, Columbus, President of the Auxiliary, called the meeting to order, Wednesday, 9:30 A. M., October 24. Reports given by the County Presidents were instructive and inspirational. The County Auxiliaries are to be congratulated upon the outstanding work they have accomplished, in spite of the handicaps of war.

Those in attendance were: Mrs. Gerald Castle and Mrs. Hugh Hengstenberg, Cincinnati, president and president-elect, Hamilton County Auxiliary; Mrs. William Singleton and Mrs. Frank Donald Traul, Cuyahoga Falls, Summit County Auxiliary; Mrs. Carl Lose, Flushing, and Mrs. C. J. Holley, Bridgeport, Belmont County Auxiliary; Mrs. Jay Calhoon, Uhrichsville, and Mrs. Paul Hisrich, Bolivar, Tuscarawas County Auxiliary; Mrs. William Singleton and Mrs. Frank Siedenburger, Portsmouth, Scioto County Auxiliary; Mrs. George Cooperrider and Mrs. Earl Baxter, Columbus, Franklin County Auxiliary; Mrs. W. W. Peirce and Mrs. L. Adams, Mansfield, Richland County Auxiliary; Mrs. L. G. Coe, Youngstown, president, Mahoning County Auxiliary; Mrs. W. B. Roads, Hillsboro, president, Highland County Auxiliary; Mrs. Fred Brosius, president, Butler County Auxiliary.

Luncheon was a very enjoyable affair and was concluded by excellent talks given by Mr. Ralph W. Jordan, Executive Director, Central Hospital Service Association, and Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association. Following luncheon the business session was resumed and reports were given by the following State Committee Chairmen: Finance, Mrs. J. L. Stevens, Mansfield; Program, Mrs. George Wilcoxon, Alliance; Public Relations, Mrs. Emerson Gillespie, Canton; Organization, Mrs. Paul Davis, Akron; Revisions of Constitution and By-Laws, Mrs. Dale P. Osborn, Cincinnati; Bulletin and Handbook, Mrs. Frank A. Riebel, Columbus; Legislation, Mrs. W. Frank Maxwell, Toledo; *Hygeia*, Mrs. H. K. Mouser, Marion; Historical, Mrs. L. L. Liggett, St. Clairsville; Convention, Mrs. Ralph Hoffman, Columbus; War Participation, Mrs. J. R. Tillotson, Lima; Publicity, Mrs. Fred W. Brosius, Middletown.

The second day of the conference opened at 9:30 A. M., Thursday, Oct. 25, with Mrs. Fidler

presiding. Mrs. David Heusinkveld, Cincinnati, secretary, read the minutes of the last meeting; Mrs. Dean Nesbit, Youngstown, treasurer's report, Mrs. Fidler, president's report; Mrs. Paul Davis, president-elect's report. Reports of the eleven District Directors were heard, followed by reports of Committee Chairmen. Luncheon concluded the successful two-day conference.

### BUTLER

Mrs. Walter H. Roehll, chairman of the Ways and Means Committee of the Woman's Auxiliary to the Butler County Medical Society, assisted by Mrs. E. McCall Morris and Mrs. Hyman Helfman, Middletown, planned a gala party for members and their husbands, Wednesday evening, October 17. Buffet dinner was served to fifty guests. Bingo and auction sales provided merriment throughout the evening. Over \$108 was realized to promote Auxiliary projects. Members of the committee were congratulated on their fine efforts.

Public relations chairman, Mrs. C. T. Atkinson, assisted by Mrs. John Borelli, Mrs. J. A. Mackie, Mrs. Corliss Keller and Mrs. Fred Brosius, collected about 500 pounds of medical samples from physicians' offices in Hamilton and Middletown. The material is being packed and sent to Polish War Relief, Akron, to be distributed to the stricken peoples of Europe.

### FRANKLIN

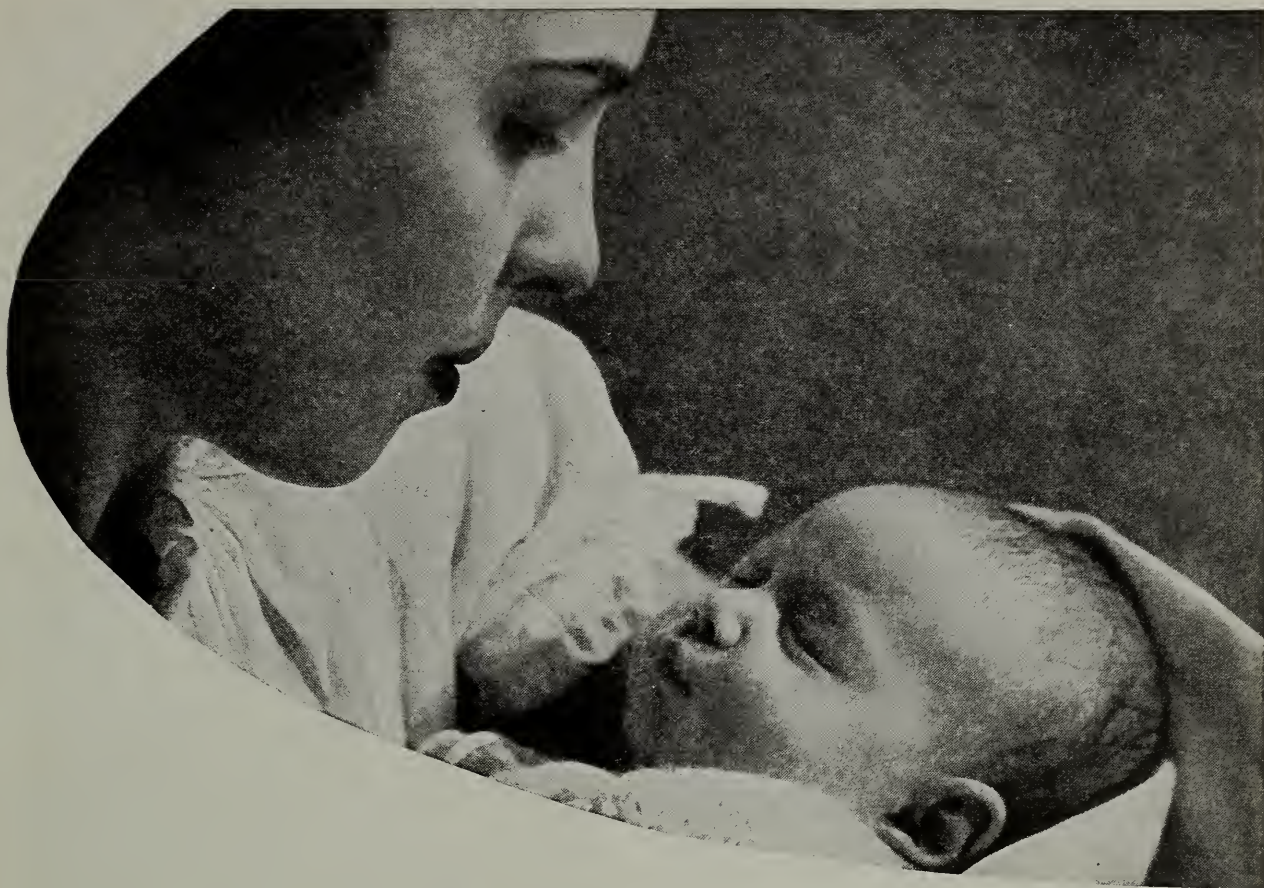
The Woman's Auxiliary to the Columbus Academy of Medicine met at home of Mrs. Fred Fletcher, Monday, October 15 at 2 o'clock. Mr. Eldon A. Parke, assistant general manager of Station WLW, was guest speaker and he was introduced by Mrs. Alban Ahn, program chairman. Mr. Parke discussed "Radio's Role in Happier and More Healthful Living". He has spent his entire business career with WLW and was formerly a Captain in the Anti-aircraft Section of the U. S. Coast Guard Artillery. A brief business session was conducted by the president, Mrs. George Cooperrider. Mrs. Robert Barnes was hostess chairman. Miss Allyn Stout, 125 S. Columbia Ave., is publicity chairman for the Auxiliary.

### HAMILTON

The Woman's Auxiliary to the Cincinnati Academy of Medicine held a board meeting which was followed by a delightful tea at the home of Mrs. Edward Wagner on Grandin Rd., Oct. 22. Activities for the coming year were discussed. Mrs. Gerald Castle, president, announced that Mrs. Parke G. Smith, public relations chairman, will have charge of the drug collection for European Relief. At present the collection will be held for the benefit of the Polish Relief.

At the tea, many wives of doctors who had been in the armed services were present and many new memberships were added to the Aux-





## Sleep insurance for doctors

To the harassed doctor, 'Dexin' brand High Dextrin Carbohydrate helps provide "sleep insurance"—nights made peaceful by fewer frantic calls from worried mothers. His 'Dexin' babies sleep more soundly, and are less subject to disturbances that interrupt slumber. The high dextrin content of 'Dexin' (1) diminishes intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds.

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Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

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iliary's roster. Mrs. A. Gerson Carmel is publicity chairman.

#### KNOX

The Woman's Auxiliary to the Knox County Medical Society met at the home of Mrs. Charles Baldwin of Centerburg, Wednesday evening.

Mrs. John Drake, president, presided over the meeting. Mrs. James Lee, general chairman of all the hospital guilds, reported that additional sewers were needed at both hospitals.

Public relations chairman, Mrs. Julius Shamansky, read a letter from the Polish War Relief chairman in Akron, thanking the group for the 300 pounds of medicine sent there for the Polish War Relief.

At the close of the meeting a book review, "The Egg and I", by Betty McDonald, was given by Mrs. Truman Hedges.

Mrs. Cooper Russell served as assistant hostess.

#### MARION

The opening meeting of the Woman's Auxiliary to the Marion Academy of Medicine was held Saturday, October 27, at Hotel Harding. The program was preceded by a luncheon, with Mrs. J. F. Smyth acting as hostess. Mrs. Frederick Rea introduced the guest speaker, Mrs. C. G. Smith. She gave an illustrated talk on "Interesting Events on a Mexican Trip", illustrating with sketches and watercolors made while spending the Summer in Mexico. Mrs. J. A. Dodd, president, has as associate officers, Mrs. Carl Sawyer, vice-president, Mrs. Richard Morgan, secretary, and Mrs. C. G. Smith, treasurer. Mrs. Frederick Rea announced that a varied program of lectures, book reviews, and travel talks had been arranged for the ensuing year. As in former years luncheon meetings will be held the third Saturday of each month. Mrs. Clarence Weber is publicity chairman.

#### RICHLAND

Mrs. Stanley Schiller and Mrs. R. D. Campbell were hostesses for the luncheon meeting of the Woman's Auxiliary to the Richland County Medical Society, at the Mansfield-Leland Hotel, September 12. Mrs. Wilmot Peirce, president, conducted the business session. Mrs. Roswell W. Fidler, President of the Woman's Auxiliary to the Ohio State Medical Association, was guest speaker and outlined the aims and projects of the state organization. Mrs. Fidler is unusually qualified to stimulate interest in County Auxiliaries, having the unique experience of serving a second year as State President.

A second meeting was held October 1 at the Women's Club, with Mrs. C. R. Damron and Mrs. Ralph Wharton as hostesses. Mrs. Wilmot Peirce presided at a brief business meeting. Bridge followed, with Mrs. D. Lavender, Mrs. C. H. Bell and Mrs. J. L. Stevens holding high scores.

The Auxiliary met Nov. 5 at the Women's Club, with Mrs. C. L. Hannum, Mrs. L. A. Smith and Mrs. H. Winbigler as hostesses. Mrs. Frank Maxwell, corresponding secretary, reports publicity for the Auxiliary.

#### ROSS

The November meeting of the Woman's Auxiliary to the Ross County Academy of Medicine was held Nov. 1 at Allyn's. Following dinner the group adjourned to Mrs. O. P. Tatman's home. Mrs. Loy Hoyt presided and Mrs. George Cooper of Clarksburg, gave a report on a meeting of the Executive Board of the Woman's Auxiliary to the Ohio State Medical Association at Columbus, October 24-25. Seventeen members were present. Sewing for Chillicothe Hospital was the project of the evening.

Plans for a Christmas Meeting on December 6 were discussed. The committee appointed for that date includes, Mrs. John Franklin, chairman, Mrs. F. W. Nusbaum, Mrs. R. W. Holmes and Mrs. Walter Kramer. Publicity chairman is Mrs. Glen Nisley.

#### SCIOTO

Members of the Auxiliary to the Hempstead Academy of Medicine voted to collect medical supplies from doctors' offices for war relief in Europe. These supplies are being shipped from the Polish War Relief in Akron. The October meeting was held at the home of Mrs. C. L. Ferguson, with twenty-five members present. Mrs. W. M. Singleton, president, conducted the business meeting and gave canteen reports. Mrs. William E. Gault reviewed the book "Home to India" by Santha Ramma Rau, augmenting the review with a collection of pictures taken by Cpl. H. W. Ziegler, while stationed in India. During the social hour, Mrs. William E. Scaggs presided at the tea urn. Mrs. H. A. Green, Mrs. C. W. Wendelken and Mrs. J. T. Murchie were assistant hostesses. Mrs. W. G. Cheney is the publicity chairman for the Auxiliary.

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#### British Films Available

British Information Services, an agency of the British Government, has made available in the United States a large number of 16 mm. sound films dealing with fighting on the various fronts and also on specialized subjects of interest to professional groups. Included in the special list are films in the fields of rehabilitation, health and medicine, e.g., psychiatry in action, plastic surgery in wartime, malaria, scabies, surgery in chest diseases, etc. Films are loaned on a nominal service charge basis. A catalog of these films can be obtained from the British Consulate, Film Division, 1673 Union Commerce Bldg., Cleveland, 14.



## Combat Exhaustion Minimized By Prompt Psychiatric Care

Approximately 90 per cent of combat exhaustion cases were returned to duty largely as a result of prompt detection of symptoms and skilled handling of the patient, it was announced by the commission of outstanding civilian psychiatrists which recently completed an 11-week survey of psychiatric conditions in the European Theater of Operations.

Members of the commission expressed their "greatest admiration for the courage, ingenuity and accomplishments" of their colleagues overseas working sometimes under fire and in the face of other serious handicaps and hazards.

Combat exhaustion cases, known as shell shock in the last war, and sometimes referred to as combat fatigue or operational fatigue, are being treated more successfully in this war because of the high quality of personnel in the field and better methods and techniques. Of the greatest importance is the fact that psychiatrists are doing some of their most effective work right up near the front at the clearing stations.

Dr. Karl Menninger, a member of the commission, pointed out that alert and understanding sergeants and lieutenants in the front lines anticipated cases of combat exhaustion. Symptoms were increasing irritability, lack of interest in letters from home and in comrades, and general lassitude and moroseness. A man who reached this stage but who has not yet come to the breaking point could usually be brought back to normal by prompt evacuation to rest camps for relief from stress of battle.

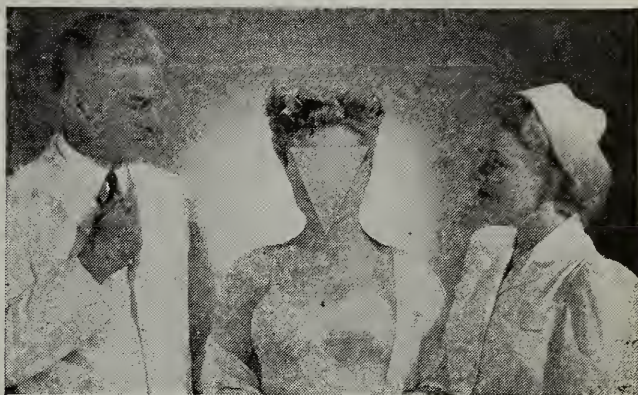
Other findings were: There is a direct ratio between the number of exhaustion cases and the intensity of combat; combat exhaustion emphatically does not mean a soldier is "yellow"; every man has his breaking point; a martyr situation more quickly induces combat exhaustion.

Other members of the commission were: Dr. John C. Whitehorn, chief psychiatrist, Johns Hopkins Hospital, and professor of psychiatry, Johns Hopkins University; Dr. John Romano, professor of psychiatry, University of Cincinnati, College of Medicine; Dr. Lawrence S. Kubie, associate in neurology, College of Physicians and Surgeons, New York; and Dr. Leo H. Bartemeier, professor of psychiatry, Wayne University, Detroit, Michigan.

Ralph H. Stone, Conneaut, has been named by Gen. Omar N. Bradley, chief of the Veterans Administration, to be deputy administrator in charge of all V.A. activities in Ohio, Michigan and Kentucky, with offices in Cincinnati. Formerly head of Civilian Defense in Ohio, Stone has been post, county, Ninth District and State Commander of the American Legion.

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# Great Work of Medical Corps Reflected in Statistics on Casualties and Sickness, Report of Marshall States

**I**N his Biennial Report to The Secretary of War, General George C. Marshall, Chief of Staff of the United States Army, paid tribute to the Medical Department for its outstanding work in World War II, as follows:

"The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters and more than 80,000,000 cases passed through the dispensaries and received outpatient treatment.

"This tremendous task was accomplished by 45,000 Army doctors assisted by a like number of nurses and by more than one-half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"One of the great achievements of the Medical Department was the development of penicillin therapy which has already saved the lives of thousands. Two years ago penicillin, because of an extraordinarily complicated manufacturing process, was so scarce the small amounts available were priceless. Since then mass production techniques have been developed and the Army is now using 2,000,000 ampules a month.

## VALUE OF IMMUNIZATION

"Despite the fact that United States troops lived and fought in some of the most disease-infested areas of the world, the death rate from non-battle causes in the Army in the last two years was approximately that of the corresponding age group in civil life—about 3 per 1,000 per year. The greater exposure of troops was counter-balanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, smallpox, and yellow fever, and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the non-battle death rate in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of the troops in this war.

## SANITATION PROGRAM

"Insect-borne diseases had a great influence on the course of operations throughout military history. Our campaigns on the remote Pacific Is-

lands would have been far more difficult than they were except for the most rigid sanitary discipline and the development of highly effective insecticides and repellants. The most powerful weapon against disease-bearing lice, mosquitoes, flies, fleas and other insects was a new chemical compound commonly known as DDT. In December, 1943 and early 1944, a serious typhus epidemic developed in Naples. The incidence had reached 50 cases a day. DDT dusting stations were set up and by March more than a million and a quarter persons had been processed through them. These measures and an extensive vaccination program brought the epidemic under control within a month. Shortly after the invasion of Saipan an epidemic of dengue fever developed among the troops. After extensive aerial spraying of DDT in mosquito-breeding areas, the number of new cases a day fell more than 80 per cent in two weeks. The danger of scrub typhus in the Pacific Islands and in Burma and China was reduced measurably by the impregnation of clothing with dimethyl phthalate.

## TREATMENT OF BATTLE NEUROSIS

"The treatment of battle neurosis progressed steadily so that between 40 and 60 per cent of men who broke down in battle returned to combat and another 20 to 30 per cent returned to limited duties. In the early stages of the war less than 10 per cent of these men were reclaimed for any duty.

"The development of methods of handling whole blood on the battlefield was a great contribution to battle surgery. Though very useful, plasma is not nearly as effective in combating shock and preparing wounded for surgery as whole blood. Blood banks were established in every theater and additional quantities were shipped by air from the United States, as a result of the contribution of thousands of patriotic Americans. An expendable refrigerator was developed to preserve blood in the advanced surgical stations for a period of usefulness of 21 days.

## RECONDITIONING PROGRAM

"So that no casualty is discharged from the Army until he has received full benefit of the finest hospital care this Nation can provide, the medical service has established a reconditioning program. Its purpose is to restore to fullest possible physical and mental health any soldier who has been wounded or fallen ill in the service of his country.

"To insure that men are properly prepared for return to civilian life the Army established 25



special convalescent centers. At these centers men receive not only highly specialized medical treatment, but have full opportunity to select any vocational training or recreational activity, or both, they may desire. Men, for example, who have been disabled by loss of arms or legs are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civil life until they have been given every possible treatment and regained their psychological balance".

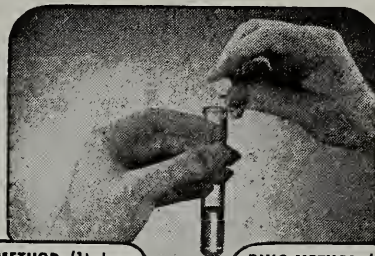
# WAR NOTES

Maj. W. E. McKee, formerly of Bryan, but now temporarily located in Louisville, Ky., was captured by the Germans in North Africa in Feb., 1943. He pulls no punches on this report of his 27 months as a P.O.W.:

"Thank you very much for those *Journals* you sent me. I am getting quite a kick out of reading where all the men are in service. With over 3,000 Ohio medics on active duty over the world, I think we have an enviable record. I was especially glad to see at intervals the names of old roommates and classmates, doing their jobs in a thorough fashion. I envy them the achievements, as I consider I was cut off in such a promising bud by the Germans at Faïd Pass.

"Would you like a quick résumé of where I was? Captured on Feb. 14, 1943, when the Germans broke through in a little Bulge at Faid and Maknassy Passes. I had been in Ireland and England for eight months the preceding year. It is just as bad as they say it was. I spent seven months as the guest of our subsequent 'valoroso'? allies? You wonder how a people could get so degenerate and servile. The Germans finally gathered us up and we were hauled into Germany Oct. 5. That was a heart-breaking month, waiting for the Americans and Montgomery to get started. They didn't.

"In Goonland I went through Oflag 64, and requested with the other M.D.'s to be sent to duty at the E.M.'s camps. Capt. Henry J. Wynsen of Youngstown and myself were sent to Hammerstein, 2-B. That was a working party camp, and we had a real headache. The Goons insisted that a man was fit for full duty four or five weeks after a hernia or appendix. So they used to have two or three-week attacks of flu following operations. Our morbidity was scandalous, but they didn't work. In July, Henry and I were moved to Stalag Luft 4, at Gross Tychow. This was new and reflected the growing animosity from the bombings. He and I with two British MOs finally had 9,800 men. A Dr. Leslie Caplan from Steubenville, O.S.U., '38, who practiced in Detroit, arrived in Nov. During the 'Black Marches' of the following Feb. and Mar., he walked with a 2,500 contingent for 87 days, doing a super-swell job for the boys, also contracting T.B. His present address is Patients Det., Fitzsimons Gen. Hosp., Denver. I did not have

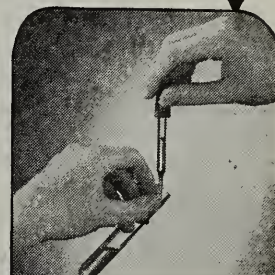
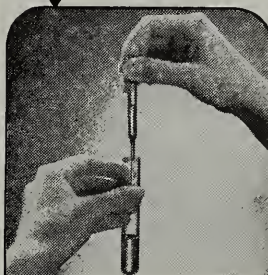


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to march. All the others did. I was left behind, I guess, as senior, with 175 who couldn't march. During this interval, till we were shipped in four box cars (40 & 8), but 20 litter cases, we had some experiences. We took care of hundreds of slave prisoners, every nationality, frozen feet, infections, starvation, new battle casualties even. I'll never forget the first time I helped one of these take off his shoes and socks. When I pulled off his socks, three or four toenails stuck to the cloth. He had been walking five days that way. I have seen nothing in print which I can not personally vouch for.

"We moved to Stalag Luft 1, March 1. It was uneventful until the Russians liberated us May 1. Only we had a four-week dry spell in March. No Red Cross food parcels. If you think a few potatoes and dehydrated vegetables make a meal try it, and only once a day. That about finishes it, I don't want to travel no more."

\* \* \*

Maj. Harry E. Chalker requests that *The Journal* be sent to his home address at Girard. He expects to be there soon, following 28 months in Alaska with the 183rd Station Hospital.

\* \* \*

After completing a 12 weeks' course at the Army School of Roentgenology, Memphis, Tenn., Maj. L. S. Zwick, Wadsworth, was assigned to the X-ray service at Nichols General Hospital, Louisville, Ky.

\* \* \*

Maj. Paul A. Blackstone, Bellville, is with an air service group at Atsugi Air Base, south of Tokyo. He arrived there from Ie Shima on Sept. 9.

\* \* \*

The United Nations Relief and Rehabilitation Administration has procured two million doses of typhus vaccine from the U. S. Typhus Commission for immunization of displaced persons in the U. S. occupation zone of Germany, according to information received at U.N.R.R.A.'s Washington headquarters from Lt. Col. David C. Elliott, Cincinnati, U.S.P.H.S., chief medical officer in the zone for U.N.R.R.A.

\* \* \*

Of the 1,400,499 decorations given in World War II in recognition of meritorious service and gallantry, six per cent were received by Medical Department personnel, according to the biennial report of General George C. Marshall to the Secretary of War. These figures are exclusive of the Air Medal and the Purple Heart.

\* \* \*

Promotion of Edward A. Noyes, Fifth Service Command surgeon, to brigadier-general was confirmed by the Senate Sept. 26. Gen. Noyes has been in the Army since 1915.

\* \* \*

Maj. Kenneth D. Smith, Columbus, chief, Industrial Medical Service, at the Rome Army Air Field, Rome, N. Y., expects to be back in civilian practice soon.

### Please Advise Us When You Go On Terminal Leave

In order that the Ohio State Medical Association can keep its records and mailing lists accurate; can keep its listings of medical officers released from the service up to date, physician veterans are urged to advise the Headquarters Office at Columbus just as soon as they go on terminal leave or are discharged. The cooperation of medical officers, and others who are in a position to furnish accurate information on this matter, is earnestly solicited.

Maj. Wm. Herman, Cleveland, overseas since Nov., 1944, is assistant chief of medicine and chief of communicable diseases of the 197th General Hospital located near Nancy, France.

\* \* \*

After being through a rugged campaign with Corps Evac. Hospital, No. 3, in Okinawa, Lt. Comdr. E. R. Torrence, Troy, moved back with his outfit to Guam, resupplied and went on to Japan. There they took over a 1000-bed Jap naval hospital at Isahya, 17 miles N.E. of Nagasaki.

\* \* \*

The Army's fourth highest award, the Legion of Merit, has been awarded to Maj. Walter R. Stager, Dover, "for exceptionally meritorious conduct in the performance of outstanding services from March 22, 1943 to June 30, 1945", according to a release from the Public Relations Office of the Alaskan Department. Maj. Stager was re-assigned to the States in September and is currently enjoying a leave with his family at Dover.

Maj. Stager was one of the first Air Corps "docs" sent to the North Pacific Isles. He pioneered the erection of facilities to maintain the health and comfort of the pilots and men and frequently had to improvise most of the gadgets he felt were needed, due to the inadequacy of supply channels in the early days. For instance, he once built a steam and bath house from old oil barrels, packing boxes and airplane parts. This bath served the pilots during both the Attu and Kiska campaigns.

One of his greatest achievements was the installation of the original Pilots' Rehabilitation Center, a prefabricated housing unit equipped with showers, steam baths, sun lamps, and recreational items for use by the air crews during long alert hours. It was the first unit accepted and shipped by the Army Air Crews.

The official citation for Maj. Stager follows: "The difficulties and problems involved in maintaining every pilot at his peak of physical and flying efficiency were quickly recognized by Maj. Stager. His responsibility was great and he executed this responsibility in a superior manner. He proved himself a master of improvisation and the words 'can't', 'impossible', and 'unavailable'



were not in his vocabulary. In caring for the individuals subject to the bleak weather conditions and monotonous daily life in the Aleutian Islands, this officer made his personality and untiring efforts a needed stimulant to the health and happiness of all members of this command. The self-sacrifice made, the intense loyalty displayed and the unrelenting devotion to duty shown by Maj. Stager during his tour of duty have contributed greatly to the activities of the Army Air Forces in this Theater."

\* \* \*

Capt. Henry Bachmann, Delaware, is with the 386th Medical General Dispensary, attached to Gen. Hq. at Manila, and "may get to see Tokyo very soon".

\* \* \*

Lt. Comdr. Joseph B. Bolin, Norwood, weathered the recent typhoon at Okinawa. He is with Special Augmented Hospital No. 6.

\* \* \*

Col. Roger O. Egeberg, Cleveland, personal physician to Gen. Douglas MacArthur, has been home on leave after three and one-half years in the Pacific Theater.

\* \* \*

Lieut. Herbert A. Markowitz, M.C., U.S.N., returned recently to his home in Cleveland, after 3½ years in a Japanese prison camp at Kyushu. He was taken prisoner at Guam in May, 1942. A former resident at Mt. Sinai Hospital, Cleveland, Dr. Markowitz graduated at Ohio State University College of Medicine in 1936.

\* \* \*

New state-side addresses: Maj. H. Howard Wood, Leesburg, Kennedy Gen. Hosp., Memphis, Tenn.; Capt. W. D. Wells, Milford, 110 B.U., Mitchell Field, N. Y.; Maj. David P. Ward, Pemberville, Med. Div. M.D.P.C., Ft. Lewis, Wash.; Capt. Rickard S. Toomey, Willoughby, Sta. Hosp., Tinker Field, Oklahoma City, Okla.; Capt. James T. Stephens, Oberlin, Sta. Hosp., Buckley Field, Denver, Colo.; Lt. William E. Sovik, Youngstown, U. S. Marine Recruiting Hdqrs., Sioux Falls, S. Dak.; Maj. Charles L. Shafer, Mansfield, Annex A, Billings Gen. Hosp., Ft. Benj. Harrison, Ind.; Lt. Col. Clyde S. Roof, Cincinnati, Surgical Service, A.S.F. Reg. Hosp., Fort Ord, Calif.; Capt. H. A. Robinson, Elyria, Scott Field, Ill.; Lt. E. H. Niesen, Cincinnati, Staff, Percy Jones Conv. Hosp., Ft. Custer, Mich.; Capt. Dean H. Minnis, Amherst, Lawson Gen. Hosp., Atlanta, Ga.; Capt. Rollis R. Miller, Cleveland, Crile Gen. Hosp., Cleveland; Capt. Herbert F. Kesinger, McArthur, A.A.F. Reg. Hosp., Greensboro, N. C.; Capt. John L. Jones, Medina, Army and Navy Gen. Hosp., Dept. of Patients, Hot Springs, Ark.; Capt. J. Robert Hudson, Cincinnati, 120th Med. Bn., A.P.O. 45, Camp Bowie, Tex.; Capt. Jos. E. Svoboda, Cleveland, Vet. Admr., 610 S. Canal St., Chicago, Ill.; Capt. W. R. Grandin, Dayton, Sta. Hosp., Indian Town Gap, Pa.; Capt. David

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\* \* \*

Maj. John J. Gallen, Columbus, now out of the service, has been awarded the Legion of Merit for his work as regimental surgeon, 148th Infantry Regiment, 37th Division, during the liberation of Luzon. According to his citation, he habitually traveled with the advance command post to set up the regimental aid station and during the intense shelling of Maleanan Palace in Manila, treated numerous casualties and exposed himself to heavy fire to supervise and assist in the loading of wounded men into ambulances.

\* \* \*

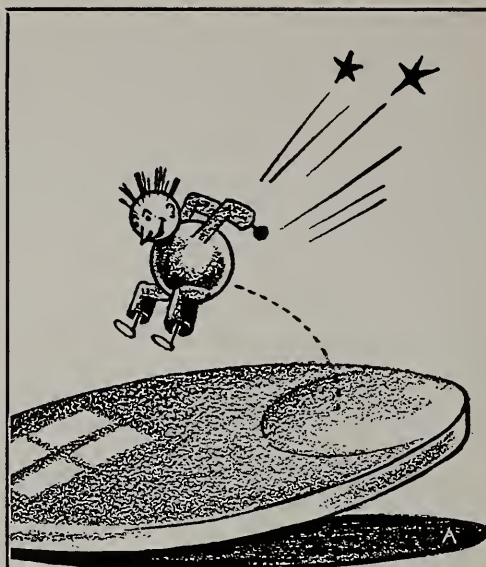
Comdr. Gerald H. Castle, Cincinnati, has been on the surgical service of the U. S. Naval Hospital, Great Lakes, Ill., since his return from 25 months overseas. While in the Pacific area he was chief of surgery and executive officer, Kaneohe Naval Air Station Hospital, Hawaiian Islands, senior medical officer and chief of surgery at Palmyra Naval Air Station Hospital and on the surgical service of the Pearl Harbor Hospital. He expects to be released from the Navy about January 1, 1946.

\* \* \*

Maj. H. H. Robinson, Cleveland, is now on duty at the Hqrs., 2274th Hawaiian Seacoast Artillery Command.

\* \* \*

Lt. Col. Norvil A. Martin, Gallipolis, is chief of the Eye, Ear, Nose and Throat Section and Rehabilitation of the Deafened at Hoff General Hospital, Santa Barbara, Calif. He entered the Army in November, 1940 and was a battalion surgeon for 14 months with the 37th Division. In Dec., 1941, he was named assistant chief of E.E.N.T. at Letterman General Hospital, San Francisco. Col. Martin went overseas as chief of E.E.N.T. with the 155th General Hospital in April, 1942, and in September of that year was made commanding officer and organized the 14th



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Portable Hospital, which was the first portable hospital flown into combat. He served with that unit during the Buna-Sanananda campaign in New Guinea before being evacuated as a patient to Australia in January, 1943. He also had duty in Sidney and Melbourne, Australia before being sent back to the U. S. for a physical disability in October, 1943.

WIN PROMOTIONS

| Name                  | City                   | Rank                 |
|-----------------------|------------------------|----------------------|
| Blazewicz, S. J.      | Columbus.....          | Capt., A.U.S.        |
| Boylan, Peter C.      | Cleveland Heights..... | Major, A.U.S.        |
| Castle, Gerald H.     | Cincinnati.....        | Comdr., U.S.N.R.     |
| Errington, A. F.      | Akron.....             | Comdr., U.S.N.R.     |
| Goodman, Julien M.    | Cleveland.....         | Major, A.U.S.        |
| Gordon, Maurice B.    | Cleveland.....         | Major, A.U.S.        |
| Grandin, W. R.        | Dayton.....            | Capt., A.U.S.        |
| Gray, James           | Cleveland.....         | Comdr., U.S.N.R.     |
| Hayden, Joseph D.     | Akron.....             | Comdr., U.S.N.R.     |
| Jones, Daniel V.      | Cincinnati.....        | Lt. Comdr., U.S.N.   |
| Kirk, Robert C.       | Columbus.....          | Lt. Col., A.U.S.     |
| Lehman, Robert G.     | Dayton.....            | Comdr., U.S.N.R.     |
| Martin, Norvil A.     | Gallipolis.....        | Lt. Col., A.U.S.     |
| Mumma, Charles E.     | Dayton.....            | Capt., A.U.S.        |
| Musser, Howard O.     | Akron.....             | Lt. Comdr., U.S.N.R. |
| Piercy, Robert L.     | Youngstown.....        | Capt., A.U.S.        |
| Robinson, Harry H.    | Cleveland.....         | Major, A.U.S.        |
| Roof, Clyde S.        | Cincinnati.....        | Lt. Col., A.U.S.     |
| Rusk, Ross P., Jr.    | Cadiz.....             | Major, A.U.S.        |
| Ryan, Nelson W.       | Cincinnati.....        | Surg., U.S.P.H.S.    |
| Schumacher, Arthur H. | Cleveland.....         | Lt. Comdr., U.S.N.R. |
| Sovik, William E.     | Youngstown.....        | Lt., U.S.N.R.        |
| Stratton, Kenneth L.  | Portsmouth.....        | Major, A.U.S.        |
| Thiessen, Norman W.   | Cleveland.....         | Lt. Col., A.U.S.     |
| Torrence, E. A.       | Troy.....              | Lt. Comdr., U.S.N.R. |

Comdr. James Gray, Cleveland, is aboard the U.S.S. Yellow Stone, Com. Det., Harbor Island, Seattle, Wash., and Lt. Comdr. F. P. Baurichter, Cincinnati, is on the U.S.S. Gen. J. H. McRae, c/o F.P.O., New York.

\* \* \*

The Bronze Star Medal for Meritorious Service has been awarded to Capt. Carl R. Damron, Mansfield, who now has 79 points and is sweating out orders to be homeward bound. Capt. Damron is chief of anesthesia with the 302nd Station Hospital at Karlsruhe, Germany.

\* \* \*

After being in the fight at Okinawa with the Navy, Lt. W. A. Nosik, Cleveland, resumed his duties as neurosurgeon to Corps Evac. Hosp. No. 1, a Marine outfit at Kamuela, Hawaii, and was preparing for the assault on Kyushu, when, happily enough, along came V-J Day. Nevertheless, he landed with the Marines at Sasebo, Japan, after a 21-day trip on an L.S.T. and set up shop in a training school of the Imperial Navy. Having little to do, Dr. Nosik has been "prowling about the country", and here's his reaction:

"Like all of Japan, the countryside is beautiful from a distance, but can not stand close scrutiny. The insult to the olfactory system is constant. Have visited the atomic bomb areas at both Nakaski and Hiroshima. The effect is even

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more terrific than we expected to see. Nagasaki is bad, but Hiroshima just isn't—it's gone. Only the shells of a few concrete buildings remain, while buzzard-like birds wheel about over the silent rubble. Flew to Tokyo and Yokohama last week—looked down on the Emperor's palace (which climaxed my Pacific campaigning). Can verify the magnificent job of devastation done by our Air Force. Tokyo and Yokohama look like a junkman's nightmare. Saw the remnants of the Nip fleet, bomb-twisted and broken in the shallow waters of Kure—a splendid sight.

"Aside of a small amount of traumatic neurosurgery brought in, time hangs heavily. Most of us have nearly enough points to get out and are getting impatient—doubly so when we are assigned duties such as being Shore Patrolmen with pistol and badge. While the policeman's job is a necessary one in service, we feel that doctors make poor police officers. . . ."

\* \* \*

More changes of address: Maj. Clarence T. Risley, Conneaut, Sta. Hosp., Chanute Field, Ill.; Maj. Edward A. Marshall, Cleveland, A.S.F. Reg. Hosp., Ft. Benning, Ga.; Comdr. Robert G. Lehman, Dayton, Med. Sec., Sep. Bn., Red. Reg't Marine Tng. and Repl. Comm., Camp Pendleton, Oceanside, Calif.; Lt. Col. Gilman D. Kirk, Columbus, chief of surgical service, Fletcher Gen. Hosp., Cambridge; Lt. Col. Robert C. Kirk, Columbus, Sta. Hosp., Ft. Knox, Ky.; Lt. Comdr. D. V. Jones, Cincinnati, Hosp. Corps School, U. S. Naval Hosp., N.T.C., Bainbridge, Md.; Maj. Maurice B. Gordon, Cleveland, Vaughn Gen. Hosp., Hines, Ill.; Lt. Col. Carl T. Doeing, Springfield, Sta. Hosp., A.A.F., Alliance, Nebr.; Lt. Col. J. O. Crist, Centerburg, Dept. of Patients, Ward 10-B, Wakeman Gen. Hosp., Camp Atterbury, Ind.; Maj. Archie Fine, Cincinnati, 3505 A.A.F.B.U., Sqn. E., Scott Field, Ill.

\* \* \*

Capt. Selin J. Blazewicz, Columbus, is on the orthopedic service of the 189th General Hospital at Mourmelon, France, between Reims and Chalons, with "practically nothing to do, the hospital T/O being kept at wartime strength". Dr. Blazewicz shipped overseas with the 663rd F.A. Bn., in Dec. 1944, and after six weeks near Chester, England, went to France, across the Rhine, and into Germany with the 8th Corps Artillery, Third Army. His outfit was with the First Army at Mittelfrohna on the outskirts of Chemnitz when the war ended. Later assignments included security guard work in Sihl, Germany, and as camp surgeon at Camp New Orleans in the assembly area of France.

\* \* \*

"The long-awaited day has arrived and the 259th Station Hospital, of which I am commanding officer, is leaving China for Uncle Sugar", writes Capt. M. L. Goldhamer, Cleveland.

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## Do You Know - - -

A two-day conference called by the Council on Medical Service and Public Relations of the American Medical Association at Chicago, Oct. 19-20 was attended by Dr. Edgar P. McNamee, Cleveland, President-Elect of the Ohio State Medical Association; Dr. Barney J. Hein, Toledo, chairman of the Association's Committee on Public Relations; Dr. A. A. Brindley, Toledo, Councilor for the Fourth District; Charles S. Nelson, executive secretary, and George H. Saville, assistant executive secretary. Dr. Edward J. McCormick, Toledo, chairman of the Council, presided.

\* \* \*

Elected at the 101st Meeting of The Northwestern Ohio Medical Association, attended by about 125 physicians at Toledo on October 9, the following are the new officers of the Association: Dr. John M. Leahy, Tiffin, president; Dr. Robert J. Semons, Carey, vice-president; Dr. Wendell Green, Toledo, secretary, and Dr. E. L. Brady, Marion, treasurer. Next year's meeting will be held at Tiffin.

\* \* \*

Hon. James W. Huffman, Columbus, recently appointed by Governor Frank J. Lausche to the United States Senate, is a brother of Dr. Iolas M. Huffman, Ravenna, and a brother-in-law of Capt. James B. Johnson, Jr., M.C., Newark, now in Japan as a medical officer with the First Cavalry Division.

\* \* \*

Annual dues of the California Medical Association have been increased from \$20 to \$100 for 1946.

\* \* \*

Dr. L. H. Huffman, Cleveland, has been reappointed by Governor Lausche as a member of the Ohio Public Health Council, for a term expiring June 30, 1951.

\* \* \*

For the first time in 62 years, the weekly *Journal of the American Medical Association* was not circulated on October 11 because of a printers' strike in Chicago which tied up more than 700 publications.

\* \* \*

Dr. Frank E. Adair, New York, chairman of the American Society for the Control of Cancer, returned to his Alma Mater, Marietta College, to be chief speaker at a luncheon, Oct. 20, for delegates to the inauguration of William Allison Shimer as eleventh president of Marietta College.

\* \* \*

The Cleveland Memorial Medical Foundation, Inc., a nonprofit organization of which Drs. R. Richard Renner, William A. Sommerfield and F. D. Butchart are trustees, has announced plans for a

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\$2,000,000, 500-bed hospital in Cleveland Heights. According to a news story, the project is being backed by 157 members of the Academy of Medicine of Cleveland.

\* \* \*

New president of the Central Society for Clinical Research is Dr. Roy W. Scott, professor of clinical medicine, Western Reserve University School of Medicine. Dr. Scott is also president of the American Heart Association.

\* \* \*

A book dedicated to the late Dr. Mont R. Reid, "Compendium on Cancer for Physicians", has been published by the Cancer Control Council of the Cincinnati Public Health Federation. Written anonymously by 25 physicians, the book will be distributed only to physicians.

\* \* \*

A portrait of Dr. Howard Dittrick, retiring after two years as president of the Cleveland Medical Library Association, has been presented to the Association. It will hang with the portraits of all past-presidents in the Allen Memorial Medical Library.

\* \* \*

University Hospitals, affiliated with Western Reserve University, have 13 women physicians as house officers, a record number, as is the number of women, 10, admitted to the Freshman class entering the School of Medicine this Fall.

\* \* \*

Among those honored with the Masonic 33rd degree in Boston recently, were: Comdr. Drew L. Davies, M.C., U.S.N.R., Columbus, home on leave from the Pacific, and Dr. John W. Wilce, Columbus, director of the Student Health Service at Ohio State University.

\* \* \*

Gen. Omar N. Bradley, Veterans' Administrator, has recommended that a 650-bed, \$4,000,000 general surgical and medical veterans' hospital be constructed in Cincinnati out of funds to be appropriated for the fiscal year ending June 30, 1947.

Edwin J. McEwan, formerly executive vice-president of the New Haven, Conn., Chamber of Commerce, has been appointed administrative director of the American Cancer Society, with full responsibility for the business management of the organization. J. Louis Neff will continue as executive director.

\* \* \*

A program for state prosperity which recognizes agriculture as basic was recommended to members of the Ohio Trade Executives Association at a meeting in Columbus, Sept. 12. Speakers included Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal* and vice-presi-

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dent of the Friends of the Land; Louis Bromfield, author-farmer, Mansfield, and H. A. Lyon, a public relations man with the Detroit Board of Commerce. Charles S. Nelson, executive secretary of the Ohio State Medical Association, and vice-president of the Trade Executives Association, presided at the meeting.

\* \* \*

The Chicago Medical Society will hold its annual clinical conference at the Palmer House, Chicago, March 5-8, 1946. All physicians are invited to attend this conference. Details can be obtained by writing the society, 30 N. Michigan Ave., Chicago 2.

\* \* \*

Dr. Elmer Lee, former New York physician, who died recently at the age of 91, left \$240,000 to Ohio Wesleyan University, Delaware, his alma mater.

\* \* \*

Dr. W. B. Wild, Mansfield-Richland County health commissioner, is one of six health commissioners in the country to be awarded a fellowship by the Commonwealth Fund for a year of graduate training. The fellowship was granted for outstanding work in the field of public health education. Dr. Wild will take his postgraduate work at the Johns Hopkins University School of Hygiene and Public Health, Baltimore, Md. During his absence, Dr. L. B. McCullough will be acting city and county health commissioner on a part-time basis.

\* \* \*

The Seventy-Ninth Annual Meeting of the West Virginia State Medical Association will be held at the Hotel Prichard, Huntington, W. Va., May 13-15, 1946.

\* \* \*

Dr. Robert H. Bishop, Jr., director of University Hospitals, Cleveland, has been named a trustee of the American Hospital Association.

### Schering Makes Appointments

Perry L. Stucker, after nearly three years in the Army, has been named Southern district supervisor for the Schering Corporation, manufacturers of endocrine and pharmaceutical preparations, and will supervise services in Oklahoma, Texas, Louisiana, Alabama, Georgia and Florida. He will be located in Atlanta. Stucker joined Schering in 1941, as assistant sales manager, and left that position to enter the Army. Another appointment is that of Allan A. Miller to the position of metropolitan district supervisor in New York.

Elyria—Dr. Richard Bell, Cleveland, spoke on "The Nurse in Industry" at a meeting of the Elyria Industrial Nurses.

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## Beware of Swindler!

Members of the medical profession and hospital attaches are warned to be on the lookout for an ex-convict, William B. Pierce, Philadelphia, who has been capitalizing on his considerable experience in hospital work by forging checks. This man stole 13 pay checks of his fellow employees and cashed them in a local bank. He is known to have worked in large hospitals in major cities. His racket is to secure endorsed checks and volunteer to have them cashed by "a friend in the bank". A good artist and one who can operate cardiograph equipment with ease, Pierce has a tendency to discuss with physicians the great possibilities of becoming rich in operating cardiograph machines. He also has a tendency to ask for a loan of \$5, with the promise to return it "on next pay day". This is done to gain the confidence of the lender. Pierce is described as: age 43; height, 5 ft. 6½ in.; complexion, medium dark; hair, dark brown; eyes, blue; build, slender. In the event this man appears in a hospital for employment, notify the local Police Department, Postal Inspectors or the F.B.I.

## Penicillin Shortage Explained

The shortage of penicillin for injection, which is causing resentment among physicians unable to secure this product for serious cases of disease, is due to "strikes, difficulty in maintaining production because of contamination during fermentation, increased export, the use of poor quality corn steep liquor and the manufacture of penicillin mixtures", according to the November 24 issue of *The Journal of the American Medical Association*.

The editorial stated that "steps are being taken to overcome the penicillin shortage. Export controls have been suggested to permit records of the quantity of penicillin leaving the United States. Directives giving hospitals first call on penicillin production have also been proposed. A higher grade of corn steep liquor is being sought".

The editorial suggested that a "step which should be undertaken by the manufacturers until the present shortage is alleviated is the discontinuance of doubtfully acting mixtures. Penicillin for injection purposes is truly a life-saving measure and its distribution should be given priority over the manufacture and distribution of over-the-counter items of less value".

## Color Film Available

"Managing Fresh Wounds of Violence", is the title of a 16 mm. full color, three-reel, silent, moving film, which Bauer & Black, Chicago, is offering without rental charge for presentation before surgical and medical groups. The film, prepared in collaboration with the Department of Surgery of the University of Cincinnati and approved by the American College of Surgeons, has been in production for over a year. Requests for bookings should be addressed to Bauer & Black, Division of The Kendall Company, 2500 South Dearborn St., Chicago 16, Ill.

Columbus—"The Newer Surgery of the Spleen", was the topic of an address made by Dr. George M. Curtis, professor of surgical research, Ohio State University College of Medicine, at a meeting of the Wayne County Medical Society, Nov. 19, at Detroit.

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## Proposed World Health Organization Receives Committee Approval

The Senate Committee on Education and Labor has released a favorable report on Senate Joint Resolution 89, which urges the speedy convening of a conference for the purpose of establishing an international health organization. The resolution was introduced by a bipartisan group of Senators including Pepper (D., Fla.), Wagner, (D., N. Y.), Murray (D., Mont.), Capper, (R., Kans.), Ball (R., Minn.), and Smith, (R., N. J.).

Calling attention to the fact that epidemics are raging in many parts of the world as a result of war disruption and deprivation, the report states that "there is today no international health agency organized or equipped to cope with many of the health problems of the rapidly changing world".

"The Committee believes", the report continues, "that the creation of such an agency is an urgent necessity for the well-being of every American citizen as well as for world health".

The proposed world health organization, which was endorsed by the San Francisco conference of the United Nations, would operate either as a division of the U.N.O. Economic and Security Council or as an agency closely related to the Council. According to the report the functions of the health organization would include:

- (1) Collection of world-wide disease statistics.
- (2) Standardization and control of drugs and other therapeutic agents.
- (3) Centralization, consolidation, and subsequent distribution of health and medical knowledge.
- (4) Assistance to national health services in controlling diseases at their sources.

The Committee report emphasized that the proposed organization would not only help safeguard the United States against epidemic diseases originating elsewhere, but by bettering health on living standards in other countries it would give impetus to American trade and industry.

"Large areas of the world", the report stated, "are unable to purchase our goods . . . The records of our export trade show that countries with relatively high standards of living buy most of our goods. If the rest of the world continues in ill-health and abject poverty, our own economy will suffer".

Yellow Springs—Dr. L. L. Taylor, 83 years old, who has been practicing medicine for almost 50 years, was acclaimed by his friends and neighbors at a community testimonial banquet recently. Many of the 2,000 infants whose births he had attended were present to hear A. C. Erbaugh, local druggist, and the toastmaster, call Dr. Taylor "all the fine things that we expect to find in the country physician".

Piqua—The Miami County Commissioners have approved a fee schedule proposed by the Miami County Medical Society covering payment for medical treatment of indigent patients in the county.

### CLASSIFIED ADVERTISEMENTS

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